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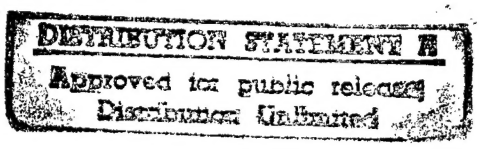

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Hospital Privileging Hearings: Striking a Balance Between Due Process and Quality of Care

Eric Israel
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INTRODUCTION

The process of medical peer review has been described as "the foundation of professionalism in American medicine" and "essential to the existence of medicine as a profession."[1] Peer review has also been identified as the crucial factor in determining whether physicians are able to maintain control over the standards of their profession.[2] It is also nearly universally accepted that hospital based peer review offers the best hope of minimizing medical malpractice, thereby controlling the "malpractice litigation crisis" and enhancing the overall quality of medical care.[3] On the other hand, peer review has also been criticized as a system through which physicians are able to cover for each other's mistakes at the expense of patients who are the victims of medical malpractice.[4] Other commentators view the process by which physicians are granted admitting privileges in hospitals, a peer review function, as one that invites abuse by those who participate in it in that they may unfairly exclude competent physicians because they are economic competitors or simply

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[1] Ronald L. Goldman, *The Reliability of Peer Assessments of Quality Care*, 267 JAMA, 19 February 1992, at 958, quoting, O'Leary, *President's* Column, *Joint Commission Perspective*, May/June, 1988, at 2.

[2] Reed and Evans, *The Deprofessionalization of Medicine*, 258 JAMA 1987, at 3279. The authors prophetically note that the move toward managed care would bring with it radical changes in the philosophy of patient care and a concomitant expectation by the people who control the funding of medical care that the practice of medicine would have to similarly change. The expressed fear was that physicians would lose their place as the preeminent decision makers with respect to therapeutic decisions. The authors argued that by focusing increased attention on peer review, the autonomy and professionalism of medicine could be preserved.

[3] See, e.g. 42 U.S.C. 11101 (1997).

[4] B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 Am. J. L. & Med. 151 (1984). The author is highly critical of the notion that the proceedings of peer review, particularly those conclusions that criticize the care rendered by the physician under review, must be maintained as confidential or physicians would hesitate to engage in honest, frank peer review. He notes that there are many exceptions which allow the publication of these materials and what is really

because they dislike the physician.[5] Some commentators disparage peer review as a mechanism that has allowed allopathic physicians to gain a stranglehold on the regulation of the practice of medicine and used it to exclude alternative systems of medicine, thereby establishing a monopoly.[6] Perhaps the most damaging attack against peer review is the challenge against its effectiveness as a means of articulating widely accepted standards of care which help to identify incompetent physicians and, ultimately improve the quality of patient care.[7]

In spite of the rather vibrant debate about the role and degree of efficacy of peer review, it seems well settled that physicians are in the best position to evaluate the competence of their colleagues, and determine whether they should continue to enjoy admitting privileges and membership on a hospital staff.[8] This is true based not only on their technical expertise, but their opportunity to observe on a daily basis the care provided by their colleagues. It is

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accomplished through the privilege is the prevention of malpractice victims from using the peer review results in negligence suits. Id, at 155.

[5] Pauline Martin Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision,* 27 Loy. L.A. L. Rev. 357, at 357-361 (1993). The author describes a hypothetical case in which several senior staff physicians use the privileging system and the threat of an adverse action against a new staff member who appears to be questioning the methods of the senior staff members. She uses this as a backdrop to propose a system whereby a physician may be better able to establish that her colleagues have acted out of malice, rather than a sincere desire to protect patient care.

[6] Michael S. Jacobs, *Testing the Assumptions Underlying the Debate About Scientific Evidence: A Closer Look at Juror "Incompetence" and Scientific Objectivity,"* 25 Conn. L. Rev. 1083, at 1109-1112 (1993). The author notes that organized medicine has used sectarian political methods to achieve professional supremacy by persuading legislatures to enact medical licensing statutes that effectively disqualified its competition. The author outlines how organized medicine has continued zealously to confront any attempt by alternative practitioners to gain acceptance, either legal or social.

[7] Id. See also Ronald R. Roth, et al., *The Attitudes of Family Practitioners Toward the Peer Review Process,* 2 Arch. Fam. Med., December 1993, at 1271.

[8] Christopher S. Morter, *Note: The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting,* 74 Va. L. Rev. 1115 (1988). "The specialized knowledge of medicine required for accurate judgments about medical performance makes other alternatives, such as lay review boards or judicial oversight, undesirable. Id, at 1118. The author also cites Campbell v. St. Mary's Hosp., 312 Minn. 379, 389, 252 N. W. 2d. 581, 587, ("...the wisdom of [a] legislative policy [which encourages

also well settled that whatever room exists for disagreement as to the degree to which peer review can deliver on its promise of improving hospital based medical care, there is virtually no question that peer review is far superior to the system of medical malpractice litigation in identifying incompetent physicians and protecting patients.[9]

Given the recognized importance of peer review in assuring quality of care, legislative and common-law efforts have been undertaken to promote active, vigorous peer review. These efforts have focused on shielding the activities and documents generated during the peer review process from discovery through statutory privileges[10] and providing some measure of immunity to physicians who participate in the process, provided they act in good faith.[11] The need for and desirability of such protections are the subject of some rather contentious debate. However, a great deal of the litigation involving peer review focuses on the degree of procedural protections which must be afforded a physician prior to any disciplinary action being taken which may affect his right to admit patients to a particular hospital.

All public hospitals must offer the physician a hearing that meets the constitutional requirements of due process if they contemplate taking adverse action against a physician and if the action is sufficiently severe to amount to a deprivation of a property interest.

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peer review] is obvious. Our ignorance of such multisyllabic terms found in the present record as 'parathyroidectomy' and 'aneurysmectomy' is no less than that shared by the general public.").

[9] See footnotes 83-88, infra, and accompanying text.

[10] See, e.g. Ariz. Rev. Stat. 36-445.01(1996); Cal. Evid. Code 1157 (1996); Fla. Stat. 395.0193 (1996); K.R.S. 311.377 (1996); Minn. Stat. 145.64 (1996); R.I. Gen. Laws 5-37-9 (1996).

Although the general minimal requirements of due process are found in the case law, even public hospitals enjoy considerable autonomy in fashioning the hearing procedures. Many, if not most, private hospitals also offer similar procedural protections, either through state mandate or because the hospital's own bylaws so require. However, many private hospitals are not required to offer a hearing that satisfies the minimal requirements of due process and chose not to. The distinction between public and private hospitals and the variety of approaches even within those classifications has resulted in an inconsistent, patchwork of hearing procedures.

These hearings, within the constraints of whatever procedure is applied, can be bitterly contested proceedings, as the physician who is the subject of privileging hearing may be facing the equivalent of a professional death sentence. The advocates for physicians who face adverse actions, as well as many commentators, believe that the procedural due process rights of the physicians should approximate those to which one would be entitled at a trial. Those who advocate on behalf of hospitals view such extensive procedural demands as creating a strong disincentive to hospitals and the staff members who participate in the hearings from challenging incompetent physicians. The material and human costs become so great and so discouraging that physicians will avoid or resist identifying instances of poor or incompetent care. In addition, the focus on the rights of the physicians and the requirement of extensive procedural protections may serve to obscure the true purpose of peer review which is to protect patients by identifying incompetent physicians. Further, the emphasis on

[11] See, e.g. Ark. Stat. Ann. 20-9-502 (1995); Conn. Gen. Stat. 19a-17b (1996); La. R. S. 37:1287 (1997); R.I. Gen. Laws 5-57-1.5 (1996); Tenn. Code Ann. 63-6-219 (1996).

the procedural rights of the physicians tends to move the hearing from a medical/scientific fact finding endeavor to a legal exercise. This may also tend to alienate those physicians who would otherwise be willing to participate.

Nearly all states, as well as the federal government have attempted to address the fear of litigation which inhibits effective peer review. The qualified immunity from liability and the qualified privileges offer some protection against litigation. Congress has addressed this concern at the federal level by passing legislation known as the Health Care Quality Improvement Act (HCQIA), which offers a qualified immunity to peer review participants, provided certain due process requirements are met. The statutory protections have been somewhat limited in their practical application. Although they increase the likelihood of a successful defense by a peer reviewer who is being sued, they do not prevent litigation altogether. The most critical limitation, for purposes of this paper is the failure of the statutory protections to address some of the issues concerning the investigation and hearing process itself, as opposed to controlling the litigation that may follow.

If peer review is to emerge as the preeminent mechanism for protecting patients from incompetent care, either through disciplining or retraining the responsible physicians, then some of the disincentives to participation inherent in the peer review process itself must be addressed. The process must be fundamentally fair and include sufficient procedural protections to prevent the abuse of peer review as a means of punishing an unpopular physician rather than protecting his patients. Toward that end, the distinction between

private and public hospitals in terms of the differing due process requirements ought to be abolished, and all hospitals should be required to offer hearings that satisfy due process. The consistent and predictable application of fair procedures will inure to the benefit of both participants in peer review as well as the subjects of peer review privileging hearings.

The procedures should not, however, approach those that would be due at a trial. Many physicians who participate in peer review perceive the intrusion of lawyers and the demands of excessive procedural protections as placing unnecessary hurdles in the way of determining the competence of physicians and protecting patients. Peer review and privileging hearings should be directed toward maintaining their character as rigorous scientific inquiry rather than directed toward satisfying the legal demands of an adversarial hearing. The physicians who must conduct, oversee and participate in peer review are not going to be as comfortable nor function as well in a setting resembling a trial as they would in an inquiry that resembles all other aspects of their training and practice. The overriding goal of peer review must be to protect the lives and safety of patients and not to promote the interests of individual physicians nor satisfy the definition of fairness as proposed by their advocates.

Part I of this paper will include a brief outline of the history of peer review, an explanation of how the process is currently applied, the efficacy of peer review and a brief comparison of the relative merits of peer review vs. malpractice litigation. Part I will also include a discussion of physicians' attitudes toward peer review. This is intended to

demonstrate that there is already some institutional antipathy toward peer review and provide support for the proposition that every opportunity to make participation by physicians more inviting ought to be exploited. Part II will argue for the merits of some degree of procedural protections even though physicians may find some aspects of legal proceedings incompatible with the scientific nature of peer review. Part III will address the traditional distinction between private and public hospitals in terms of the amount of procedural protection to which a physician is entitled at peer review hearings, concluding that this distinction should be eliminated, and that all hospitals provide procedures that, at a minimum satisfy the constitutional standards for due process. Part IV will propose some specific approaches to the hearing that will ensure due process, but place reasonable limits on the respondents' demands, help avoid litigation following the peer review hearings and encourage active participation by medical staff members.

PART I

An Overview of Medical Peer Review

A. The History of Peer Review.

The notion that the regulation of physicians could somehow result in improved care is not necessarily a modern convention. The regulation of physicians, beginning with the institution of the Hippocratic Oath, has its roots in ancient history, at the birth of the

profession of the healing arts. Not all efforts have been so rooted in benign persuasion as that oath. In 2000 B. C., the Code of King Hammurabi of Babylon admonished physicians that the negligent killing of patients would cost them their hands.[12] Not surprisingly, the substitution for such external controls with an internal system of medical peer review is considered to have originated with the advent of the organization of the medical profession.[13]

The history of peer review in the United States can be traced back as far as 1649, when Massachusetts sought to impose such collegial oversight.[14] As early as 1760, the states began to regulate the practice of medicine by creating boards of medical examiners to evaluate the competence of individuals wishing to practice and to grant licenses to those whom they considered qualified.[15] The boards were composed of physicians, as it was believed that only those who actually studied and practiced medicine could properly judge whether another was competent to do so.[16] Not coincidentally, the advent of early regulation of the medical profession tracked the development of formal medical education,

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[12] Jacqueline Oliverio, *Hospital Liability for defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, but Words May Cost me my Job*, 92 W. Va. L. Rev. 739, 740 (1990), (citing Fine & Meyer, *Quality Assurance in Historical Perspective*, 28 Hosp. & Health Serv. Admin., Nov.-Dec. 1983, 94, 94.)

[13] John E. Graf, Patrick v. Burget: *Has the Death Knell Sounded for State Action Immunity in Peer Review Antitrust Suits?*, 51 U. Pitt L. Rev. 463, 464 (1990).

[14] Flanagan, *Rejecting a General Privilege for Self-Critical Analyses*, 51 Geo. Wash. L. Rev. 551, 560 n. 58 (1983). "The Province of Massachusetts passed an ordinance that no 'Churgeons, Midwives, Physitions or others' were to practice 'without the advice and consent of such as are skillful in the same art (if such be had) or at least some of the wisest and gravest then present.' " (citing R. Shyrock, *Medical Licensing in America 1650-1965*, at vii (1965)).

[15] Kathleen L. Blaner, *Physician, Heal Thyself: Because the Cure, The Health Care Quality Improvement Act, May be Worse than the Disease*, 37 Cath. U. L. Rev. 1073, 1078

[16] Id.

which burgeoned following the American Revolution.[17] In spite of these early efforts, most graduates were felt to have been poorly educated and incompetent.[18]

In response to the continuing problems of physician competence, the American Medical Association was founded in 1847 to establish practice standards.[19] Many states' licensing boards either adopted these standards or independently promulgated minimum standards for licensure.[20] In either case, the Supreme Court held the promulgation and enforcement of minimum standards for licensure to be a valid exercise of the states' police power.[21]

In spite of these efforts, the quality of medical care was still considered poor. This prompted an action which is believed by many to have ushered in the modern era of medicine. The Carnegie Foundation commissioned a survey of the quality of medical education, to be conducted by Abraham Flexner.[22] His findings, published as the Flexner Report,[23] was a rather severe indictment of the poor quality of the education and competence of physicians.[24] The report prompted the American College of Surgeons to establish standards for medical education both at the University level and for interns and

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[17] Comment: *Medical Peer review Protection in the Health care Industry*, 52 Temple L. Q. 552, 554. (1979).
[18] Id.
[19] Id.
[20] Blaner, supra note 15, at 1078.
[21] Dent v. West Virginia, 129 U.S. 114 (1889).
[22] Joseph A. Saunders, *The Other Side of the "Gatekeeping" Coin*, 18 Whittier L. Rev. 105, 106 (1996).
[23] A. Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* 3-4 (1910).
[24] Saunders, supra note 22, at 106.

residents practicing in hospitals.[25] This inevitably led to the standardization of hospitals themselves, to include organized medical staffs.[26]

As the demand for hospitals grew following the second World War, the federal government encouraged the enactment of state licensure laws that reflected the ACS standards.[27] In 1952, the Joint Commission for the Accreditation of Hospitals (JCAH), now known as the Joint Commission for the Accreditation of Health care Organizations (JCAHO), a private regulator of health care quality, was formed.[28] One of the purposes of the JCAH was to continue the development of rigorous hospital standards, to include assuring highly competent staff members.[29] The critical nature of effective peer review and the importance of JCAH accreditation were underscored by two developments. Congress made accreditation by the JCAH a sufficient qualification for hospitals to be eligible to participate in the Medicare program,[30] and the JCAH, as a condition of accreditation, required hospitals to implement comprehensive peer review programs.[31] In addition, a body of case law grew which held hospitals liable for the negligent failure of its agents to provide

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[25] Id.

[26] *Comment; Medical Peer Review Protection in the Health Care Industry*, supra, note 17. The author describes how the leadership of the American College of Surgeons was composed of primarily teaching and close-staff hospitals, and that the standards reflected that bias. Among the biases reflected in the standards was a view that membership in a hospital staff was a privilege that should be conferred solely on merit as determined by the current staff of each hospital.

[27] Id., at 555

[28] Id. The JCAH included members from the ACS, the American College of Physicians, the American Hospital Association, the American Medical Association, and for a brief period of time the Canadian Medical Association.

[29] Id.

[30] 42 U.S.C. 1395(bb) (1996).

[31] *Comprehensive Accreditation Manual for Hospitals: The Official Handbook,* January 1997, at MS-1-12

adequate care as well as any failure to review adequately the competence of its staff members and to take appropriate action with respect to their privileges.[32]

Peer review is now perceived as one of the most critical functions of the medical staff, both in terms of limiting the hospital's exposure to liability as well as assuring the highest quality of health care for its patients. However its ascendancy to its perch at or near the top of importance of hospital and medical staff functions has not been without some criticism and legal challenge. Many commentators note that the ACS used its control of standardization, and thereby the admission to medical staffs, to promote the economic and professional domination of medicine by allopathic practitioners, to the exclusion of other less conventional approaches.[33] Needless to say, the peer review process has spawned a great deal of litigation, both by the public, the intended beneficiary of peer review, and the physicians who have either been denied staff privileges or, once having been granted privileges have them limited or revoked.[34] Although the early challenges by physicians were based on civil rights arguments, more recently antitrust complaints have served as a useful means of challenging adverse privileging action.[35]

B. The Process of Peer Review.

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[32] See, e.g. Darling v. Charleston Community Memorial Hospital, 211 N. E. 2d 253; Gonzales v. Nork, N. 228566 (Superior Court, Sacramento County, Cal., Nov. 19, 1973); Elam v. College Park Hospital., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982).

[33] Saunders, supra note 22, at 107-108. The author notes that "allopathy" is defined as a "system of medical practice that aims to combat disease by use of remedies producing effect different from those produced by the disease treated."(Citing Webster's Third New International Dictionary 57 (3rd. ed. 1976)). The author identifies "naturopathy," Osteopathy," and "homeopathy" as competing systems.

[34] Id.

[35] Id.

Most modern hospitals are governed by a set of bylaws which typically place the ultimate legal responsibility to deliver quality care on the board of directors, but bifurcates the responsibility for the management of the hospital between the directors, who manage the administrative functions, and the medical staff, to whom the responsibility for the delivery of medical services is delegated.[36] The medical staff is to monitor the quality of care as well as provide a mechanism for supervising and controlling the professional conduct of the individual medical staff members. The supervisory function is what is essentially known as peer review.[37] In order to compartmentalize the peer review duties, hospitals are organized into departments and committees.[38] Some committees, such as the surgical review committee or the blood utilization review committee have highly specialized functions and will supervise and report primarily on the limited aspects of care they are chartered to oversee.[39]

For purposes of this paper, the most important committee function is the credentials committee. The grant of admitting privileges at a particular hospital is one of the most important aspects of modern medical practice, particularly for specialties such as surgery or obstetrics and gynecology.[40] However physicians are not entitled, even if licensed by the

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[36] Id, at 108.

[37] Peer review has been defined as "the evaluation by practicing physicians of the quality, efficiency and effectiveness of services ordered or performed by other physicians." Oliverio, supra note 12, at 742 (Citing W. Iselle, *The Hospital Medical Staff-Its Legal Rights and Responsibilities* 126 (1984).

[38] Morter, supra note 8, at 1115.

[39] *Comment: Medical Peer Review Protection in the Health Care Industry*, supra. Note 17, at 557.

[40] It has been noted and widely repeated by commentators that a physician without privileges will soon be a physician without a practice. See, e.g. Karen G. Seimetz, *Note: Medical Staff Membership Decisions: Judicial Intervention*, 1985 U. Ill. L. Rev. 473.

state, to practice at any hospital they so chose. Typically, a physician must apply for privileges, or credentials, before they may admit patients and practice in a hospital. The applicant must submit a written application and proper documentation of educational and clinical experience.[41] The application is then reviewed by the appropriate clinical department, which makes a recommendation to the credentials committee with respect to the granting of privileges. Usually, considerable deference is shown to the determination of the clinical department, as they are specialists and are considered best able to assess the qualifications of an applicant.[42] Ultimately, the executive committee and the board of directors receive and act upon the recommendation of the credentials committee whether to grant or deny the applicant privileges.[43]

The monitoring of a physician's performance through peer review is an ongoing process at both the department and committee level. This is often accomplished by routine retrospective review of the therapeutic decisions and outcomes of the physicians' patients.[44] Often, this routine review will disclose some problems, which are then addressed through the peer review process. Most deficiencies are corrected with little conflict. However, some physicians may be perceived to have provided such poor care in a particular case, or a sampling of cases, that some action is required. Deficiencies are not only identified through

[41] Id.
[42] Id.
[43] Morter, supra note 8, at 1117.
[44] Seimetz, supra note 40, at 477.

the routine retrospective review. Often a colleague identifies the deficiency and brings it to the attention of an appropriate medical staff officer.[45]

The medical staff officer or the executive committee may summarily suspend the privileges of the identified physician. This is done when the deficiencies in care are immediately apparent and the safety of the patients requires such immediate action.[46] More typically, an investigation is conducted, with findings and recommendations forwarded to the credentials committee.[47] If the credentials committee or the executive committee intends to recommend some adverse action, usually revocation of some or all of the physician's privileges or limitation of some or all of the privileges, the physician is entitled to a hearing at which he may contest the findings and recommendations.[48] If the recommendation following the hearing continues to be some type of adverse action, then the physician is typically entitled to an appeal.[49] The procedure applied at the hearing may vary according to the bylaws of the hospital, the laws of the state, or the status of the hospital as public or private.[50]

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[45] Rosen, supra note 5, at 381-383.

[46] The United States Air Force, in accordance with Air Force Instruction (AFI) 44-119, follows a procedure which is fairly standard for state and federal agencies, and is consistent with the bylaws and procedures of many private hospitals as well. The current draft of the revised version of AFI 44-119, ch. 7, para. 7.5, authorizes summary suspension in response to gross provider misconduct, incompetence or negligence that is self-evident and threatens patient safety. Suspension is also authorized pending the completion of an investigation or retraining, rehabilitation and reevaluation. Id, at para. 7.8.

[47] Id, at para. 7.3, 7.14.

[48] Id, at para. 7.15-7.25

[49] Id, at para 7.26-7.29.

[50] See footnotes 117-170 infra, and accompanying text.

A significant proportion of adverse privileging decisions become the subject of litigation. This has not always been the case, but as hospitals grew to be a central feature of health care delivery, and highly expensive hospital based technology grew to dominate the therapeutic approach, admitting privileges became the sine qua non of an economically viable practice. The incidence of litigation in the federal courts saw a rather pronounced rise when the Supreme Court ruled that the antitrust laws applied to the professions as well as commercial activity.[51] This allowed physicians to challenge adverse privileging decisions as the product of anti-competitive motives rather than the desire to maintain quality care. This is an especially attractive vehicle for challenging peer review decisions as the statutes allow for treble damages.[52] In addition, the passage of civil rights statutes outlawing discrimination in employment related decisions offered a vehicle through which women and minorities could challenge privileging decisions as motivated by discriminatory purposes.[53] These protections were added to the already available due process challenges. State actions for antitrust violations and discrimination, as well as defamation, intentional interference with a contractual relationship and breach of contract round out the panoply of available causes of action by a physician aggrieved by an adverse privilege decision.

C. Physicians' Perspectives of Peer Review

[51] Goldfarb v. Virginia State Bar, 421 U. S. 773 (1975).
[52] 15 U.S.C. 15 (1997).
[53] 42 U.S.C 2000e, et seq.; 42 U.S.C. 1981 et. Seq.

Given the apparently overwhelming institutional support for peer review,[54] one would expect that the individual practitioners would approach the ethical[55] and professional responsibility of peer review with a positive attitude. Although there is little empirical study of physicians' attitudes toward peer review,[56] the available data,[57] as well as anecdotal evidence,[58] seems to suggest that many, if not most, physicians approach peer review with a sense of dread and mistrust. Clearly the prospect of being sued accounts for much of the antipathy regarding evaluating one's peers, but the confluence of many factors probably account for the negative feelings expressed regarding peer review.

1. Physicians' Attitudes Toward Peer Review

A recent study provides some insight into the perception of physicians regarding current peer review practices.[59] Using a survey instrument, the researchers sought to measure the perceptions of family physicians, surgeons and hospital based physicians.[60] The authors

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[54] See footnotes 1-3, supra, and accompanying text.

[55] See E. Haavi Morreim, *Am I My Brother's Warden? Responding to the Unethical or Incompetent Colleague,* The Hastings Center Report, May 1993, at 19. The author provides an excellent ethical framework for approaching the problem of an incompetent colleague. He offers reasons based in professionalism, patient autonomy, law, and economics to justify his conclusion that, in spite of the many disincentives to identifying an incompetent colleague, one has an ethical responsibility to do so.

[56] See, Roth, et al., supra note 7, at 1272. The authors report that a MEDLINE search from 1976 to the writing of the article (1993) yielded no studies that analyzed the collective perceptions of physicians toward specific aspects of the peer review process.

[57] Id.

[58] See Arthur Owens, *Peer Review: Is Testifying Worth the Hassle?*, Med. Econ., 20 August 1984, at 167.

[59] Ronald R. Roth, et al., *The Attitudes of Family Physicians Toward the Peer Review Process*, 2 Arch. Fam. Med., Dec 1993, at 1271.

[60] Id. Four specific areas of the process were measured; (1) how peer reviews are administered; (2) the educational value of peer reviews; (3) the performance of peer review committees; and (4) the effect of the peer review process on physician morale. The survey was mailed to all 3528 physicians who were members of a state medical society, of whom 1695 were family physicians, general surgeons and hospital based physicians. Of that 1695, 774 (46%) responded.

noted at the outset that the definition of peer review has evolved during the past twenty years, largely due to external pressures, from the evaluation of one's work by one's equivalents in their field of endeavor to any review of professional medical activity, to include review by true peers or by external parties.[61] The questionnaire contained 17 items, the responses to which were used as a measure of the respondents' attitude. More than one half of the family physicians responded negatively on every item and over 70% responded negatively on five of the items.[62] The authors concluded that all specialty groups express some dissatisfaction with the peer review process, with surgeons responding most negatively.[63] Significantly, it was in the area of physician morale that most dissatisfaction was expressed.[64]

Perhaps the authors' most significant comment is that the changes that are being proposed to address the dissatisfaction with peer review involve shifting the focus from the individual case review method to system level approaches.[65] The goal of such an approach is to realize the objective of continuous quality improvement, that is improving the mainstream of care by establishing nationally uniform criteria and applying such criteria to

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[61] Id. The authors note that much of the general dissatisfaction toward peer review in general and the specific negative responses elicited in their survey seems to be directed at the outside influences that grow out of government mandated peer review. They specifically cite the professional standards review organizations (PSRO's) and later the professional review organizations (PRO's) that Congress establishes as part of the Medicare and Medicaid programs. Nevertheless, it seems that these feelings can probably be generalized to true peer review performed in hospitals pursuant to bylaws, state regulation or JCAHO mandate. Presumably the hospital based peer review committees and the physicians tasked with investigating and reporting on their colleagues will be applying virtually the same standards and asking the same questions.

[62] Id, at 1272.

[63] Id, at 1275.

[64] Id.

[65] Id. at 1274-1275.

practice patterns and outcomes, as opposed to dealing with individual clinical errors.[66] While such a systems approach may promote that goal, the peer review system, as it is applied to determine the competence of an individual physician whose care may be under scrutiny, necessarily involves evaluating the individual cases of that physician using either locally established criteria or those national criteria derived as part of the continuous quality improvement efforts. Thus, one of the more troubling aspects of peer review, and one which is the target of a fundamental change, must remain an integral part of the process as it relates to identifying incompetent physicians.

2. The Efficacy of Peer Review

Another significant finding concerned the extremely negative attitude of the surveyed physicians toward the educational value of peer review. Fewer than 30% agreed that it reduces poor practice or functions as an educational process.[67] Only 15% believed that peer review encourages the best medical decisions.[68] This attitude no doubt reflects the perception that medicine is still largely considered an art as much as a science,[69] and that individual treatment decisions are largely a matter of intuitive judgment based on years of subjective observation rather than clearly established, widely accepted standards of practice.

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[66] Id. at 1275, citing Jencks and Wilensky, *The Health Care Quality Improvement Initiative,* 268 JAMA 1992, at 900.
[67] Id., at 1273.
[68] Id.
[69] Rosen, supra note 5, at 369-370.

The available data certainly seems to support a somewhat jaundiced view of contemporary peer review practices. One researcher conducted a meta-analysis of 12 previously published studies which examined the agreement between reviewers of their evaluations of patient care episodes based on review of medical records or abstracts of the records.[70] They found that physician agreement regarding the quality of care is only slightly better than the level expected by chance.[71] Other similar studies seem to demonstrate that the one consistent element of quality assessment is that there is considerable disagreement among physicians as to standard of care.[72] A 1986 Rand Corporation attempt to establish practice parameters for a variety of diagnostic and surgical procedures resulted in agreement among the experts on only 3 to 41 percent of the possible indications for the procedures.[73]

The above is an example of the criticism that questions whether medicine is, in fact, a discipline that consistently and properly applies scientific principals to determine appropriate care and achieve some measure of consensus among its practitioners as to acceptable clinical modalities. One commentator notes that only ten to twenty percent of all medical procedures in use as of 1990 had undergone randomized clinical trials, the gold standard for

[70] Goldman, supra note 1, at 958.
[71] Id., at 959. The author discussed several recommendations for improving the process of peer review, such as using multiple reviewers and allowing them to discuss their differences of opinion, establishing more objective procedures, employing true experts to assess other physicians' care and establishing practice guidelines. However, the author noted that peer review in its current form will continue to be used until another measure of quality of care is proven to be better.
[72] Rosen, supra note 5, at 367-370.
[73] Id., at 368, (Citing Billings, *The Emergence of Quality as a Major Health Policy Issue*, in *Medical Quality and the Law* 21, 29 (John Billings et al. Eds., 1990)).

determining the efficacy of a therapy.[74] Further, often when long-standing practices have been put to stringent scientific testing, they are shown to have little or no significant clinical value.[75] In addition to these failings, the work of John Wennberg has challenged the claim that medicine seeks and discovers the truth through objective scientific inquiry.[76] He examined the practice patterns of physicians practicing in close geographic proximity and found a wide variety in treatment approaches for similarly situated patients. The lack of any scientific reason underlying the difference highlights the absence of professional agreement on standards of care.[77]

3. The Personal and Professional Cost of Participating in Peer Review

The threat of being a defendant in a lawsuit is the most obvious and most quantifiable disincentive to participating in the peer review of one's colleagues. However, there are many other costs which a physician may have to bear for participating in the peer review process, particularly if the outcome is harmful to another physician's career. One commentator noted that physicians who have testified before peer review or credentials

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[74] Jacobs, supra note 6, at 1108.
[75] Id.
[76] Id., at 1109. (Citing John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action,* Health Aff., Summer 1984, at 6).
[77] As an example the author cites a finding that in one area of Vermont 8% of children received tonsillectomies, while in another area 70% underwent this procedure. He also notes two areas of Maine which had rates of hysterectomies for women over 70 of 20% and 70% respectively. Id. The author concludes by with the following observations:

"Taken together, these examples from the scientific literature reveal the uncertain and fluctuating nature of medical truth. ... Thus, much of what passes for medical science has never been subjected to any form of scientific testing. Doctors themselves seem unable to develop or provide any neutral criteria for assessing their own professional conduct, and the wide variations in many forms of seemingly simple medical practice point to the absence of any lodestar of objective medical truth."

committees reported having lost referrals and experiencing hostility, not only from the physician under review but other colleagues as well.[78] About two percent of the physicians interviewed reported having refused to testify against incompetent peers.[79] Several physicians noted that even a favorable outcome to litigation does not make participation more inviting.[80] Another common complaint is that little if any action is taken following a good faith complaint against another physician.[81] One of the most telling complaints from the physicians who were questioned is that the process of peer review takes too long and is too labor intensive.[82]

D. Peer Review vs. Tort Litigation

In spite of the many perceived and actual weaknesses inherent in current peer review procedures, the only alternative appears to be the medical malpractice tort system. This alternative is clearly not as efficacious a means of preemptively identifying physician error and systematically improving medical care. The empirical data overwhelmingly demonstrates that the incidence of actual malpractice far exceeds the incidence of

[78] Owens, supra note 58, at 167.
[79] Id.
[80] Id, at 168. One physician noted he received little or no support from the hospital; another noted he was sued for reporting a psychiatrist who had sex with a patient; several cases were described in which the complaining physicians had what appeared to be impeccable motives, yet were sued, prompting one physician to voice the familiar refrain that lawyers were destroying the ability of decent physicians to protect their hospitals and their patients.
[81] Id, at 169. One physician reported feeling as though he had been chastised when he criticized a colleague, but no action was pursued against the other physician. Another physician claims to have been ridiculed and embarrassed when he spoke out against an impaired colleague and was threatened professionally if he persisted. He stated the lesson he learned from his experience was to keep his mouth shut. Id.
[82] Id.

malpractice claims.[83] The now famous Harvard Medical Practice Study in New York is perhaps the most frequently cited study to establish this point. Using cases from the year 1984, the researchers determined that there were approximately 98,000 adverse events for hospitalizations in the state of New York.[84] Approximately 27,000 were attributable to negligence.[85] When the researchers compared this number to the incidence of malpractice claims for the study year, they determined that approximately eight times as many patients suffered an injury due to malpractice as filed a malpractice claim and 16 times as many suffered an injury as received compensation from the tort liability system.[86] The gap between the actual incidence of malpractice and the filing of claims is even wider when one considers how many claims are filed that do not involve negligent care.[87]

The tort system is also extremely unlikely to reduce the incidence of malpractice or otherwise to improve the quality of medical care. The threat of being sued does not necessarily act as a deterrent to negligent care. The incidence of lawsuits that do not involve negligent care alone would probably be enough to undermine the effectiveness of the tort system as a quality assurance mechanism. In addition, given the frequency of suits that do not involve actual negligence, it is unlikely that physicians will consider the tort system a

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[83] Gregory C. Peters, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine,* 10 Am. J. L. & Med. 115, at 120, n. 32. The author notes a study done at two community hospitals by the Department of Health Education and Welfare which showed that of the 517 patients injured by negligent care, only 37 filed malpractice claims.

[84] Barry R. Furrow, et al, *Health Law 2d ed.,* at 32-33 (1991).

[85] Id.

[86] Id.

[87] Peters, supra note 83, at 120. The author cites many reasons that are offered to account for the rapid rise in medical malpractice claims other than negligent care. Increased use of health care systems, the erosion of the physician-patient relationship, a general rise in all litigation and the increased expectation of a good outcome due to advances in medical technology.

reliable learning tool. However, other features of malpractice litigation undermine it as well. Some commentators believe it actually has a negative impact on quality care as it harms the physician-patient relationship and promotes unnecessary testing and procedures.[88] The widespread mistrust within the medical profession of the tort system and the attorneys who benefit by it is almost certain to continue to preclude any possibility that physicians will view the system as capable of making a meaningful contribution to improving quality care.

E. Protecting and Promoting Peer Review.

Peer review clearly suffers from many perceived and actual deficiencies, particularly the lack of consensus regarding standard of care and the "non-scientific" nature of medicine, that cost it some credibility both in and out of the medical profession. At first glance, this may seem to support other approaches to identifying and disciplining incompetent or negligent physicians, or, at a minimum, assuring that physicians are protected from such an uncertain and unpopular system by granting an extensive array of rights and procedures to challenged physicians. However, the better reasoned response to the weaknesses in the current system is to deal with them directly and promote and nurture a vigorous approach to peer review. It would be more effective to improve the process to the point where it has a great deal more credibility, and effectiveness Physicians must be encouraged and not punished for setting and enforcing standards in their profession.

[88] Id.

Peer review is clearly the best mechanism for identifying impaired and incompetent physicians. The failure by physicians to engage in vigorous, demanding peer review will inevitably harm patients. Peer review should be structured and implemented with patient safety as the paramount concern. The rights and convenience of physicians should not enjoy equal status, nor be afforded the same consideration as patient safety. Of course, there is potential for abuse, and any system of peer review must be designed to identify and correct abuses, however, that should be a residual benefit of the system. Public policy demands that we err on the side of promoting safety and not on the side of allowing potentially incompetent physicians to continue to practice.

Part II

Peer Review: Scientific Inquiry vs. Legal inquiry

A. The "lawyerization" of peer review investigations and privileging hearings

The threat of litigation following peer review hearings and the social and professional costs do not stand as the only disincentives to participation in peer review. The co-opting of the peer review and hearing process by the legal profession can serve as a source of frustration to the physicians who participate.[89] Much of this is probably due to a certain amount of professional antipathy toward attorneys, attributable largely to their role in the malpractice tort system. But a much more fundamental difference inherent in the approach

of the two professions to discerning "the truth" probably comes into play. In order to meet the legal demands of due process, or otherwise satisfy the applicable legal requirements, the hearings take on the nature of an adversarial process, which is fundamentally different from a scientific inquiry.[90]

Although many attorneys will describe a trial as a search for the truth, a zealous advocate is not engaged in the same type of single minded search for the truth as one engaged in a scientific or historical inquiry.[91] Rather, advocates search for a particular truth that favors their position and attempt to obscure the truth for which their adversary is searching.[92] Further, science is expected to be neutral as to the truth that is uncovered, rejecting a scientific analogue to the exclusionary rule if some truth is discovered by means that are morally or politically objectionable.[93] In short, the goal of scientific inquiry is to determine objective truths, verifiable and replicable by accepted scientific tests.[94]

On the other hand the law deliberately imposes barriers to determining truth. The burden of proof beyond a reasonable doubt in criminal cases is one such barrier. It is premised on the notion that it is better to allow ten guilty men to go free than one innocent man to be convicted.[95] Thus, the legal system is willing to sacrifice a "truthful" outcome ten times in order to assure a single "truthful" outcome when it entails denying a person his freedom. In

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[89] See footnote 97-103 infra, and accompanying text.
[90] Allan Dershowitz, *Reasonable doubts*, at 34-48 (1996).
[91] Id, at 35.
[92] Id.
[93] Id, at 36.
[94] Id, at 37.

addition, the exclusionary rule serves as a barrier to truth, promoting the societal values of privacy and freedom from unwarranted searches or coerced confessions at the expense of the consideration of what is often "truthful" evidence.[96] It is no wonder that such a system would be anathema to those who are trained to seek objective truth through scientific inquiry. Thus, it should come as no surprise if physicians perceive that once lawyers are introduced into the process and the legal system influences the outcome of peer review hearings, then the truth suffers.

It has been suggested that the extensive panoply of due process rights which the law demands may be the single most potent deterrent to effective peer review.[97] The prospect of conducting a hearing sufficient to discourage litigation, or to maximize the likelihood of a favorable outcome probably convinces many committed physicians not to recommend adverse actions with respect to the credentials of another physician.[98] The demands of due process and judicial review nearly always results in the early and intensive involvement of hospital counsel in the evaluation of the physician and the ultimate drafting of the notice to the physician, particularly the allegations underlying the proposed adverse action.[99] The preparation of witnesses prior to the hearing involves extensive attorney time and the hearing itself, which usually requires the presence of hospital counsel, may take weeks or

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[95] Id, at 39-40.
[96] Id, at 42.
[97] Paul L. Scibetta, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review,* 51 U. Pa. L. Rev. 1025, 1035 (1990).
[98] Id, at 1037.
[99] Id.

even months, sometimes driving attorney costs into hundreds of thousands of dollars.[100] The costs of preparing a transcript, extensive research and copying of documents, and obtaining outside expert consultants or witnesses can also be extremely high.[101] However, the costs to the individual physicians most compromise the effectiveness of peer review. A participating physician must devote a great deal of time to committee meetings, review of the subject physician's medical records, preparation for hearing testimony, and the hearing itself.[102] In addition, the physician must endure as grueling a cross examination as at a trial.[103] All of this comes at great personal cost, as this effort requires time away from the physician's own practice, family and other pursuits, explaining why some physicians are simply unwilling to participate.[104]

The primary purpose of peer review is the improvement of the quality of care. However, the primary goal of any attorney is to promote the interests of his client, within the bounds of law and ethics, without thought or consideration to the greater societal good. The greater the procedural and substantive rights we give to the physician, the greater the power we cede to attorneys to control the outcome and process, regardless of whether the hearing produces the "correct" result. The commentary by attorneys who practice extensively in this area aptly demonstrates this point.

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[100] Id.
[101] Id.
[102] Id.
[103] Id.
[104] See Owens, supra note 58.

Attorneys who represent hospitals are likely to assist in the preparation of the presentation to the privilege hearing committee. Their orientation is going to be toward assuring that the strongest possible case is presented to support the challenged action.[105] They will assure that the notice of charges to the physician can withstand due process scrutiny, and that any procedural lapses or violations by respondents' counsel work to the detriment of the respondent, even though that may promote an incorrect outcome.[106] A particularly vexing problem is one of repeated continuances. The strategy can benefit the defending practitioner by allowing him to continue to practice if he has not been suspended, and the delay could create witness problems, as well as a fading corporate memory regarding the original problem with the physician.[107] There is thus a tactical advantage to the hospital to move the hearings along, while delaying tactics may work to the benefit of the respondent, regardless of whether either action would contribute to a correct outcome.[108]

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[105] Mark A. Kadzielski, *Peer Review Hearings: Nuts Bolts and Flakes*, 14 Whittier L. Rev. 147, 149-152 (1993).

[106] Id. The author specifically refers to Cal. Bus. & Prof. Code 809.2(d) which requires the exchange of documentary evidence no later than thirty days before the hearing. Often the challenged practitioner releases nothing to the medical staff. The author note he has been successful in excluding documentary evidence at hearings when the challenged practitioner has either deliberately or through inadvertence failed to comply with the demands of discovery. While this may be legally justifiable, it certainly does not promote the goal of a correct outcome if the documentary evidence is highly exculpatory.

[107] Id, at 152.

[108] Id, at 153. Although the author readily conceded that his presentation took the medical staff perspective, because that is his usual role in peer review hearings, he commendably offered a good deal of advice to similarly situated attorneys that focused on assuring the hospital was pursuing a reasonable course. For example, he urged hospital attorneys to consider who investigated the case and be sure that the accusers are not acting out of anti-competitive motivation, or because they are simply out to "get" the other guy. Id, at 149. He also advised hospital attorneys to consider whether less extreme forms of discipline may be appropriate in cases requiring hearings. Id.

To some counsel who specialize in representing physicians at privileging hearings, the hearing is perceived as the only "trial" a physician will ever receive, and should be dealt with accordingly.[109] One commentator compares the process of appealing a committee decision to judicial review, in that the appellate body determines if the committee decision was supported by substantial evidence.[110] He concedes that the board is unlikely to substitute its medical judgment for the physicians (the board is usually comprised of non-physicians), therefore, the focus of an appeal often should be on identifying procedural errors by the committee and convincing the board that they merit reversal of an adverse decision.[111] Another commentator characterizes it as "wonderful," when the hospital is not represented by counsel and must rely on a physician to present the case, as they are usually unfamiliar with the process and enter the hearing woefully unprepared.[112]

The hearing committee ought to be singularly oriented toward an objective determination of the fitness of the physician to continue to practice. If such an objective determination of the physician's fitness can be made in spite of some procedural lapse or failure to adhere strictly to hospital bylaws, those procedural flaws should seldom, if ever, justify overturning a

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[109] See, e.g., Joseph A. Saunders, *Peer Review Hearings: Nuts Bolts and Flakes*, 14 Whittier L. Rev. 155, at 155-156. (1993)
[110] Id, at 157.
[111] Id.
[112] Anthony Hunter Schiff, *Peer Review Hearings: Nuts, Bolts and Flakes,* 14 Whittier L. Rev 161, 164 (1993). The author somewhat proudly writes of other success he has enjoyed by focusing on flaws in the process rather than persuading the committee that the underlying substantive reasons for terminating or limiting a physician's privileges are invalid. For example, he writes of the advantages that are to be gained because the committees typically write poor decisions, with little documentation of their findings and conclusions. Id, at 165. In defense of this commentator, it is only fair to note that he does acknowledge that intensive preparation to confront the substantive medical issues and an orderly and skilled presentation of the refutation of the charges is the most critical aspect of these cases. Id, at 162-163.

board decision or requiring a rehearing. It is just this type of result that can be so discouraging to physicians. There is bound to be resentment and resistance when peer review participants who accept the burdens connected with identifying and acting against poor providers of care see their efforts undone for reasons that do not affect the ultimate truth of their conclusions. If the procedural lapse is not relevant with respect to the issue of whether a physician did or did not do that with which he is charged or whether the care rendered was or was not substandard, then it should not be the basis for invalidating a hearing result.

This is not to suggest that physicians, who are somewhat vulnerable to personal attack and could be the victims of an improper action should be stripped of procedural protections. There are some commentators who decry the imposition of procedural due process as completely inimical to promoting quality of care.[113] However, there are, in fact, many benefits to be derived from a consistently applied process that assures some measure of fairness to physicians. There is no question but that the erroneous or capricious deprivation of a physician's privileges works to the detriment of quality care. It is not simply a neutral event. It limits the available choices of potential patients and it destroys the continuity of care of the patients already being treated by the physician facing loss of privileges. In addition, it simply cannot be denied that there are instances in which physicians are unfairly targeted by their colleagues for adverse privileging actions. Such targeted physicians ought to be heard on this issue. There are many benefits to the participants as well. A procedural

[113] See, e.g. Scibetta, supra note 97.

format helps give some structure to the hearing. It helps those who have little or no experience from operating in the dark.

Perhaps the greatest benefit to the participants in peer review is that sufficient due process is the best assurance of avoiding post-hearing litigation, not only with respect to due process issues, but all the other bases for liability often charged by aggrieved physicians. Due process is the lynchpin for realizing the qualified immunity offered by HCQIA.[114] A well structured hearing process with some limited "trial-type" protections should be presented to potential peer reviewers as an up-front price to pay for the assurance of the finality of their actions and a valid way of avoiding the even more oppressive exercise of litigation and continuing appeals. However, the requirement of some due process and the benefits to be derived should not be treated as a mandate for an oppressive, tedious, untimely procedure which elevates the form of the hearings above the goal of patient safety. The art is in assuring sufficient procedural protections to comply with constitutional demands, where applicable, and to assure the protection of the qualified immunity offered by HCQIA. At the same time the process should maintain the "scientific nature" of peer review, simplifying and streamlining the process and encouraging active, vigorous participation. A discussion of the development and application of general due process requirements will follow in part III. Part IV will then address some specific issues of due process often raised at hearings and propose an approach to some of these issues.

[114] See footnotes 195-223, infra and accompanying text

Part III

Due Process and Privileging Hearings

A. The Public/Private Hospital Distinction

The fifth and fourteenth amendments to the United States Constitution guarantee procedural due process under those circumstances in which the government seeks to deprive an individual of life, liberty or property.[115] Some form of government action is typically the threshold requirement of support for a claim of a violation of due process.[116] During the historical development of the application of due process requirements to hospital privileging actions, there was a distinction drawn between public and private hospitals, with only the former being required to offer some form of procedural due process prior to denying privileges to an applicant or taking adverse action against a physician already on staff.[117] A private hospital was essentially directed only by its own bylaws, and was free to take adverse action at will.[118] The majority of jurisdictions still recognize a more or less unfettered right of private hospitals to deny or revoke medical staff privileges for any reason or for no reason and even for reasons that do not implicate patient care.[119] This position has come to be

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[115] U.S. Const. Amend. V ("No person shall be…deprived of life, liberty or property, without due process of law."); U.S. Const. amend. XIV, clause 1 ("No state shall…deprive any person of life, liberty, or property without due process of law.")

[116] Peter E. Borkon, *Exclusive Contracts: Are Constructively Terminated Incumbent Physicians Entitled to a Fair Hearing?,* 17 J. L. Med. 143, 152. (1996).

[117] Thomas Katheder, *The Medical Staff Privileges Problem in Florida,* 12 Fla. St. U. L. Rev. 339, 342 (1984).

[118] Id.

[119] Seimetz, supra note 40, at 482..

known as the rule of non-review.[120] There has been considerable erosion over the years of the distinction between public and private hospitals due both to common-law and statutory changes, as well as public policy changes. A brief review of the development of staff privileges in public hospitals as a constitutionally protected interest follows in order to establish a framework for discussing the changes in the private hospital arena.

1. Constitutional Due Process and Privilege Hearings

The case of *Board of Regents v. Roth*[121] was largely responsible for redefining employment as a constitutionally protected property interest. Although the Court ruled that a non-tenured professor at a public university did not have a property interest in continued employment which entitled him to procedural due process prior to his termination,[122] the Court developed a test in order to measure when continued employment amounts to a property interest sufficient to warrant the protections of procedural due process. The Court noted that Roth was hired for a limited term of employment, one year, and nothing in the terms of the employment contract created a mutual expectation of continued employment between the parties.[123] The Court explained that property interests are not created by nor defined in the constitution, rather the property interest is invested by state law or by a rule

[120] Chester A. Groseclose, Jr., *Hospital Privilege cases: Braving the Dismal Swamp,* 26 S. Dak. L. Rev. 1 (1981).
[121] 408 U.S. 564 (1972).
[122] Id, at 578.
[123] Id.

or understanding known to both parties that raises the expectation of continued employment.[124]

Once a right to due process is established, the next issue which must be addressed is the form which any procedures must follow in order to satisfy the demands of due process.[125] Due process has remained a very fluid and flexible notion, as the variety of circumstances and interests to be protected is practically unlimited. In some cases, simple notice has been enough.[126] In other cases a comprehensive hearing with all the trappings of a trial, to include the right to be represented by counsel, to cross-examine adverse witnesses, to present one's own evidence and to have an independent fact-finder, is offered to an individual facing a deprivation of property.[127] The Court employs a balancing test to locate where along this spectrum a specific interest should fall.[128] In *Mathews,* the Court employed a three part balancing test which weighed; the importance of the individual interest at stake; the risk of error inherent in the existing procedures; and, the probable value of additional

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[124] Id, at 577. The Court also acknowledged that a liberty interest in continued employment could also require constitutional protection. Id. The Court has developed what is known as the "stigma plus" test. This four step analysis requires a finding of; 1) a stigmatizing reason for dismissal; 2) the dismissal and reason are disseminated beyond the privacy of the employee-employer context; 3) the dismissal is challenged by the employee; and 4) any deprivation of liberty must also involve the concurrent loss of a state-created right or status. See Carolyn Quinn, *Procedural Due Process Rights of Physicians Applying for Hospital Staff Privileges,* 17 Loy. U. Chi. L. J. 453,458 (1986).

[125] Quinn, supra note 124, at 460 (citing *Goss v.Lopez,* 419 U.S. 565, 577 (1975); *Morrissey v. Brewer,* 408 U.S. 471, 481 (1972)).

[126] Id, citing Board of Curators v. *Horowitz,* 435 U.S. 78, 84-85 (1978) ("When student was dismissed on academic grounds, faculty's warnings to student of dissatisfaction with academic performance were sufficient to satisfy fourteenth amendment due process requirements"), id.

[127] Id, citing Goldberg v. Kelley, 397 U.S. 254, 266-71 (1970) ("Welfare recipient threatened with termination of benefits was entitled to pre-termination evidentiary hearing, including timely notice, opportunity to confront adverse witnesses and present oral evidence, counsel, impartial decision maker and written record of proceedings"), id.

[128] Mathews v. Eldridge, 424 U.S. 319 (1976).

procedures and the interest of the government in avoiding the administrative and financial burdens that would result from the additional procedures.[129]

Nearly all courts and commentators agree that the balancing test, when applied to the circumstances of a privilege hearing, ultimately requires procedural protections not quite as extensive as those usually provided in a trial,[130] yet a physician is typically granted a wide range of procedural rights when faced with denial or revocation of staff privileges. They include: (1) notice of the time and place of the hearing; (2) an opportunity to be heard; (3) a reasonably definite statement of the allegations against the physician; (4) the right to cross-examine adverse witnesses; (5) the right to produce witnesses on one's own behalf; (6) an impartial decision-maker; and, under some circumstances, (7) the right to be represented by counsel.[131]

2. Private Hospitals and due process

Initially, courts drew a distinction between public and private hospitals with respect to the reviewability of privileging decisions. The "overwhelming weight of authority" favored the right of a private hospital to grant, deny and revoke privileges at will, unchecked by judicial oversight or any requirement of due process.[132] Over the past thirty years, there has

[129] Id.
[130] See e.g. Klinge v. Lutheran Charities Ass'n . of St. Louis, 523 F.2d 56, 63 (8th Cir. 1975).
[131] See e.g. Milford v. People's Community Hosp. Auth. , 155 N. W. 2d 835, 839 (1968).
[132] Shulman v. Washington Hospital Center, 222 F. Supp. 59 (D. C. 1963)

been some erosion of the wall of protection around private hospitals. There have been common-law, statutory and policy developments that have either mandated due process procedures prior to adverse privileging actions or have made it so attractive even to private hospitals, that such procedures are implemented for the benefits the hospital will derive.

Two cases, both decided in 1963, *Shulman v. Washington Hospital Center*[133] and *Greisman v. Newcomb Hospital*[134] challenged the notion that private hospitals could not be held accountable for the manner in which they dismissed staff members. In *Shulman*, The plaintiff sought to extend his courtesy staff privileges for the year 1963, but he was turned down by the hospital with no apparent reason cited in the record.[135] The court discussed at length that private non-profit hospitals, even if they receive public support and even though they serve a public function are private actors, and therefore need not accommodate all who seek to practice there.[136] However, in critical dicta, the court noted that an exception to the rule could apply in those cases in which a hospital fails to abide by its own rule, by-law or regulation, in which case judicial review would be undertaken for the limited purpose of assuring compliance with such a rule and not to second guess the judgment of the hospital.[137] Building on the framework that private hospitals may create judicially enforceable rights in favor of physicians through rules, bylaws or regulations, some courts have held that a right to procedural due process may be enforceable against private

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[133] Id.
[134] 192 A. 2d 817 (N. J. 1963).
[135] *Shulman,* 222 F. Supp., at 60.
[136] Id, at 60-62.
[137] Id, at 62-63.

hospitals.[138] In *Lowe v. Scott,*[139] The court of appeals acknowledged that the grant of privileges by public hospitals creates a property interest and that by establishing bylaws offering a pre-revocation hearing a hospital satisfies the requirement in *Roth*[140] of creating a mutual expectation of continued employment.[141] However, the court took the holding one step further declaring that a state may create a property interest, by statute or case law, in hospital privileges, entitling all physicians to due process.[142] "It is the state itself, rather than the hospital as a state employer, that has created the `legitimate claim of entitlement' to the protected interest in privileges."[143]

3. The Quasi-Public hospital

In the *Greisman*[144] case, an osteopathic physician challenged a hospital's denial of his application for privileges. The denial was based on a bylaw that required all staff members to be graduates of a medical college approved by the AMA.[145] The plaintiff was a fully licensed physician practicing in the state of New Jersey in a private practice that included service as a school physician and an industrial plant physician.[146] The New Jersey Supreme Court discussed the growing acceptance of osteopathy as a scientifically based school of medicine rather than a cult-like practice, and in reliance on that widespread and growing

[138] Lowe v. Scott, 959 F.2d 323 (1st Cir. 1992).
[139] Id.
[140] 408 U. S. 564 (1972).
[141] Lowe, 959 F. 2d, at 335-336.
[142] Id.
[143] Id.
[144] 192 A. 2d 817.
[145] Id, at 819.
[146] Id at 818.

acceptance considered it unreasonable, arbitrary, capricious and discriminatory to exclude such physicians from hospital practice.[147] In order to grant relief to plaintiff, the court had to address the defense that defendant was a private hospital and its privileging decision should therefore be immune from judicial review.[148] The court acknowledged the difference between public and private hospitals, but ruled that private hospitals are private only in the sense that they are non-governmental, and in all other respects are dedicated to a vital public purpose.[149] The court observed that far less public activity than the running of a hospital has been subject to judicial oversight to promote the common interest or the needs of the public.[150] The court held that this quasi-public function justified judicial oversight of physician privileging.[151]

The acceptance of the quasi-public categorization as a basis for judicial review of privileging decisions has not enjoyed rapid or widespread acceptance. One commentator cites New Jersey, Alaska, California and Hawaii as the only jurisdictions that apply the rule,[152] while another cites eight states as indicating a willingness to review the staffing decisions of private hospitals.[153] Nevertheless, there have developed other bases, both statutory and common-law on which to rest a requirement that even a private hospital provide some procedural protections to physicians who face adverse privileging recommendations. Several states have passed legislation that mandates some form of

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[147] Id at 824.
[148] Id at 820.
[149] Id at 821.
[150] Id at 822-823.
[151] Id at 824.
[152] Borkon, supra note 116, at 160.

procedural protections to any physician who is the subject of adverse privileging actions.[154] The statutes vary widely in the degree to which they purport to influence the type and degree of process that is provided to physicians who become the subject of a peer review hearing.

4. Statutory demands for due process in private hospitals

California mandates a very detailed and fairly uniform procedure for conducting peer review hearings and provides a substantive standard for denial or revocation of privileges.[155] The statute requires notice to a physician when a peer review body is proposing an adverse action, including notice of the specific recommended action, notice of the right to a hearing and notice of the time limit within which to request a hearing.[156] If a hearing is requested, then a physician is entitled to additional notice of the specific reasons for the proposed adverse action, including the specific acts or omissions charged and the time, place and date of the hearing.[157] The physician is entitled to input on the manner in which a trier of fact is to be selected, and no such trier of fact may have any prior involvement in the investigation of the physician or in the recommendation for adverse action.[158] The physician may conduct reasonable voir dire of the panel to expose bias, and is entitled to discovery of all relevant

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[153] Groseclose, supra note 120, at 13.
[154] See, e.g. Ind. Code Ann. 34-4-12.6-2 (e) (1996); Tex. Health and Safety Code 241.101 c; Miss. Code Ann. 73-25-93 (1); Fla. Stat. 395. 0193 (1996); Cal. Bus & Prof. Code 809.1-809.8 (1996)
[155] Cal. Bus. & Prof. Code 809.1-809.8 (1996).
[156] Id at 809.1 (b) (1)-(4).
[157] Id at 809.1 (c) (1)-(2).
[158] Id at 809.2.

evidence, with a rather expansive statutory definition of relevance.[159] The procedural rights at the hearing are virtually indistinguishable from the full panoply of rights at a judicial proceeding. The only outstanding exception is that each hospital is free to determine whether a physician may be represented by counsel, but if the peer review body is so represented, then, as a matter of law, so must be the physician.[160] In the case of an adverse finding and recommendation by the hearing body, the physician is entitled to appellate review, which need not be de novo review, but includes the right to appear and respond and the right to be represented by counsel or some other representative.[161]

Not all statutory schemes are so detailed in outlining the due process rights of physicians. California is unusual and possibly unique in the degree of detail with which it addresses the rights and procedures attendant to an adverse privileging action. Texas, for example, merely requires that the process for considering the applications for privileges (and presumably taking adverse action against privileges which have already been granted) afford each physician procedural due process.[162] The statute does not address what specific procedures are required nor if the standard is based on the requirements of the fourteenth amendment. Pennsylvania requires that all hospital bylaws establish fair hearing and appellate review mechanisms to be available, if requested by a physician, in connection with medical staff recommendations for the denial of reappointments or the curtailment, suspension or

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[159] Id.
[160] Id at 809.3
[161] Id at 809.4.
[162] Tex. Health & Safety Code 241.101(c).

revocation of privileges.[163] This statute has been held to render moot the former dichotomy between public and private hospitals as to the scope, if any, of judicial review and to completely obviate the need to address whether a hospital is quasi-public.[164] The applicable state act as well as HCQIA were held to apply to all hospitals without differentiation as to their public or private status and to be the remedy for any acts by a hospital which arbitrarily harmed a physician.[165]

Some states have codified the suggestion of the *Shulman*[166] court that a hospital should be legally obligated to abide by its own bylaws. Mississippi authorizes private hospitals to take adverse action against physicians provided they "comply with the hospital and/or medical staff bylaw requirements for due process."[167] Many other states have adopted by common law rather than statute the rule that all hospitals, to include private hospitals, must abide by their bylaws pertaining to privileging decisions.[168] Some jurisdictions treat the requirement to follow the by-laws as one arising out of contract rather than the requirements of due process.[169] Private hospitals have also been required by statute to adhere to due process standards by meeting the requirements of the JCAHO.[170] Florida authorizes adverse privileging actions but requires the hospital to conform its hearing procedures to those of the

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[163] 28 Pa. Code 107.12
[164] Allison v. Centre Community Hospital, 604 A.2d 294, 297 (Pa. 1992).
[165] Id.
[166] 222 F. Supp. 59 (1963).
[167] Miss. Code Ann. 73-25-93 (1).
[168] See, e.g. Scappatura v. Baptist Hospital of Phoenix, 584 P.2d 1195, 1197 (1978); Knapp v. Palso Community Hospital, 531 N. E. 2d 989 (1988).
[169] Gianetti v. Norwalk Hospital, 211 Conn. 51, at 63 (1989).
[170] Fla. Stat. 395.0193; R. I. Gen. Laws 23-17-23 (1996).

JCAHO, among other accrediting agencies, and to establish their procedures through the hospital bylaws.[171]

B. Bringing Balance and Consistency to Due Process

This survey of the mechanisms by which private hospitals are required to afford some procedural protections to staff physicians demonstrates a certain lack of consistency and clarity as to whether, and under what circumstances, the applicable rule entitles the physician to constitutional due process or something less and whether the remedy will be a civil rights claim, a contract claim or some other avenue of relief.[172] The term due process has been applied generically to any hearing preceding an adverse privileging action, without regard to the source of the requirement or whether the hearing would satisfy constitutional standards. There may not be a practical difference regardless of how the procedure is characterized, either as one satisfying the demands of due process or fundamental fairness.[173] Under the case law, fundamental fairness appears to be quite similar to the requirements of due process.[174] Nevertheless, this still leaves the manner of enforcement and the procedural standards uncertain.

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[171] Id.
[172] Groseclose, supra note 120, at 13.
[173] Id.
[174] See, e.g. Silver v. Castle Memorial Hospital, 497 P.2d 564 (Hawaii 1972).

In the case of *Lake Hospital and Clinic v. Norman,* [175] the court noted that Florida, by virtue of Fla. Stat. 395.0193, had eliminated the distinction between public and private hospitals as far as the protection of staff privileges.[176] Although the court acknowledged that section 395.0193 required private hospitals to afford the same protection as public hospitals, it held that relief for the failure to do so was under the statute, and not a state or federal due process claim. The First Circuit in *Lowe*[177] also demonstrated the degree of uncertainty in this matter. The court noted that a review of the case law makes clear the only way privileges in a private hospital become a property interest is by statute or judicial decision requiring "all" hospitals to provide adequate process.[178] This comment does not appear to acknowledge the cases in which courts have held that the bylaws of a private hospital, if they include a requirement for a fair hearing and revocation for cause only do, in fact, create a property interest. Presumably these rulings would apply only to the specific hospital in question, and not extend to "all" hospitals, as suggested in *Lowe.* In addition, Rhode Island, like Florida, passed legislation that authorized adverse privileging action in any licensed facility provided the bylaws included a fair hearing procedure consistent with the requirements for accreditation by JCAHO.[179] The *Lowe* court seems to have either overlooked the statute or rejected the analysis of the *Lake* court that such a statute renders moot any distinction between public and private hospitals for purposes of minimal procedural protections prior to final adverse privileging actions.

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[175] 551 So. 2d 538 (Fla. 1989).
[176] Id, at 544.
[177] 959 F. 2d 323.
[178] Id at 338.
[179] R. I. Gen. Laws 23-17-23.

1. The argument for limited due process rights

Some commentators view the development of the right to extensive procedural due process as counterproductive to a hospital's role in enhancing and assuring the quality of care.[180] The hospital has changed from a setting in which one physician took care of the patient with the hospital providing nursing and other largely non-medical services to one in which the patient is treated by a team of care givers who fall under the management of the hospital. Further, not only is the hospital more involved in the care, it is answerable in tort for its failure to assure that only competent physicians obtain staff privileges. The public interest may have been well served by providing extensive procedural due process to physicians facing loss of privileges when care was defined in terms of one physician looking after one patient[181] However, the modern role of a hospital focuses much more on assuring high quality care, and this responsibility often is in direct competition and conflict with the interest of a physician in maintaining privileges.[182] Thus the greater deference given to physicians' interests, the more the hospital is frustrated in its effort to assure quality.

The case of *Silver v. Castle Memorial Hospital*[183] stands as an example of how the needs of physicians are often protected at the potential expense of the needs of hospitals and patients. The Supreme Court of Hawaii acknowledged that the hospital has an interest in

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[180] See, e.g. Quinn, supra note 124; Scibetta, supra note 97.
[181] Scibetta, id, at 1030.
[182] Id, at 1026-1029.
[183] 53 Haw. 475, 497 P. 2d 564 (1972), *cert denied*, 409 U.S. 1048 (1972)

maintaining its autonomy in staff selection and that there is a public interest in the hospital vigorously assuring high quality care.[184] Nevertheless, the court also imposed on all hospitals the requirement that procedural due process, to include, among other procedures, adequate notice of specific deficiencies or charges and then adequate time to prepare a defense prior to the date of the hearing.[185] This aspect of the decision was not particularly controversial nor unduly burdensome to the hospital. What is remarkable is that the court specifically did not address or even consider the issue whether the hospital's decision to revoke plaintiff's privileges was substantively justified, but chose to grant an injunction reinstating his privileges based simply on what was concededly a badly flawed hearing.[186] Thus the court was willing to risk placing a potentially incompetent physician back into active practice for the duration of what could have been a very lengthy hearing process. It is one matter to insist that the hospital right its wrong and provide a fair hearing, imposing all the attendant financial and personal costs of repeating the process. It is quite another matter to conclude that because the process was flawed, the outcome necessarily must be as well. It simply is not justified to place patients at risk because a hospital failed in its obligation to follow proper procedures.

The high cost to peer reviewers and hospitals of providing extensive due process prior to taking any type of meaningful action is seen as such an impediment to effective peer review and credentialing that some commentators advocate the abolition or significant scaling back of the procedures to which doctors are currently entitled. This approach is both unrealistic

[184] Id, 497 P. 2d at 570.
[185] Id, at 572.

and highly undesirable for many reasons. The instances of the abuse of the system to "punish" or harm unpopular or controversial physicians for reasons other than the quality of their medical care are probably quite rare. Similarly, privileging hearings are most often sincere efforts to provide a physician with a reasonable opportunity to be heard. However, the instances of abuse occur with enough frequency and are often so flagrant that they invite or demand some external review.

One court has characterized the procedures which were the subject of review as having the "notable stench of unfairness."[187] One of the concurring justices in *Silver* referred to the proceedings in that case as a "Kafkaesque `kangaroo court,' called at the eleventh hour in an effort to comply with the hospital's own bylaws and to rationalize a result which its board of trustees had already reached."[188] As long as the actions and decisions of some privileging committees create that type of impression, it is highly unlikely that a judiciary or legislature will completely surrender what oversight they possess in the form of enforceable procedural standards. In addition to addressing these outlying cases, there are strong public policy arguments as well as substantial benefits to affording due process that justify its application to hospital privileging.

2. The case for universal procedural due process protections

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[186] Id.
[187] Rosenblit V. Superior Court (Fountain Valley Regional Hosp. And Medical Center), 231 Cal. App. 3d 1434, 1445, 282 Cal. Rptr. 819, 825 (Cal. App 4 Dist., 1991).
[188] Silver v. Castle Memorial Hospital, 53 Haw. 475, 491, 497 P.2d 564, 575.

The better reasoned approach is to eliminate the distinction between public and private hospitals with respect to the procedures to which a physician is entitled and to establish a uniform requirement that physicians facing adverse actions be offered procedures which satisfy minimal due process requirements. Private hospitals not only face the same array of extensive governmental regulation,[189] but to patients and physicians, they are virtually indistinguishable.[190] An arbitrary dismissal of a qualified physician from the staff of a private hospital is as damaging to a career and reputation as is a dismissal from a public hospital. Perhaps of greater importance, such an action may effectively deny patients the opportunity to continue to be treated by the physician of their choice at the hospital of their choice. Neither outcome promotes the ultimate goal of peer review; improved quality of care.

One argument for eliminating the distinction between public and private hospitals is that all hospitals that engage in peer review may ultimately take action that significantly impacts a physician's ability to practice medicine anywhere in the United States and may also affect the status of their state licenses.[191] The axiom that the mere grant of a license should not automatically confer unlimited privileges at any hospital of a physician's choosing evolved out of the notion that even public hospitals are free to set higher standards than a state does to issue a medical license. For example, many hospitals require board certification or a completed accredited residency as a condition of a grant of specific clinical privileges.[192] However, a denial of privileges often follows a physician, rendering it very difficult to obtain

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[189] Seimetz, supra, note 40, at 483-485.
[190] Id.
[191] Id, at 486-491.
[192] But see, Silver v. Castle Memorial Hospital, 53 Hawaii 475, 497 P.2d 564

privileges at other hospitals.[193] Thus, the action of unfairly and arbitrarily denying or revoking a physician's privileges is quite likely to have a ripple effect that could render it impossible for the physician to continue to practice in that state or any other. What starts as a privileging action may quickly have the practical effect of an adverse licensing action.

This phenomenon of privileging taking on a quasi-licensing role is neither objectively undesirable nor an accident of design. When the two independent functions are working properly, they have a complementary and synergistic effect. The state makes an initial determination that a physician is minimally qualified to practice general medicine. Few people seriously argue that market forces or individual consumers would perform this role effectively. However, the license is usually the same for all physicians and does not limit or control the specialty areas in which a physician can practice. It is the function of privileging that assures that a physician is capable of performing in highly complex and specialized areas that require considerable training and experience which exceed the qualifications for a license.[194] Further, once a license is granted, the state has little active role in supervising the competence of physicians. Medical boards usually react based on reports by other physicians or patients. The most active role they play is usually to require the payment of a fee and provide some evidence of having participated in continuing medical education as a condition of the renewal of a license. The ongoing process of peer review may provide the only meaningful protection the public has against physician incompetence. Congress recognized

[193] See, e.g. Burkhart v. Community Medical Center, 432 S. W. 2d 433 (Ky. 1968).
[194] Seimetz, supra, note 40, at 489.

this and sought to protect peer review as a nationwide system of policing the quality of health care.

3. HCQIA and procedural due process.

The passage of HCQIA was the result of the confluence of several developments in the health care arena. Although the denial and revocation of staff privileges had long been the subject of litigation brought by aggrieved physicians, there was a sharp increase in the number of antitrust suits after 1975.[195] Prior to that year, physicians enjoyed the benefit of the learned profession exception to anti-trust laws.[196] The exclusion was premised on the notion that Congress did not intend to treat the practice of a profession as trade or commerce, and that competition is inconsistent with a profession, as the goal of a professional practice is not profit, but to provide a public service.[197] However, the rejection by the Supreme Court of the learned profession exception seemed to open the floodgates on anti-trust litigation aimed at adverse privileging actions.[198] The growth in anti-trust litigation was particularly troubling as it exposed physicians to treble damages if it was found that their privileging action violated the statute, and it allowed the aggrieved physicians to gain access to the federal courts, thereby avoiding state immunity and privilege provisions regarding peer review activity.

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[195] Graf, supra, note 13, at 469.
[196] See Goldfarb v. Virginia State Bar, et al., 421 U.S. 773 (1975).
[197] Id, at 785.
[198] Graf, supra note 13, at 470. The author notes that in the five years between 1875 and 1980, there were nearly five times as many health care related anti-trust suits as were brought in the first 85 years of anti-

The case of *Patrick v. Burget*,[199] is widely considered to be the anti-trust case that served as the impetus for HCQIA. Dr. Patrick, an employee of the Astoria Clinic declined an invitation to become a partner, choosing to begin his own independent practice in the same community.[200] He continued to serve as a member of the staff at Columbia Memorial Hospital (CMH), the only local facility. He then became the target of what appeared to be retaliatory treatment.[201] Eventually, a member of the clinic requested a review by the CMH executive committee of Dr. Patrick's privileges, and, when the executive committee voted to recommend termination of his privileges he was offered a hearing, as per the bylaws.[202] The hearing committee was chaired by another Astoria Clinic partner, who had earlier participated in state Board action against Dr. Patrick.[203] Dr. Patrick resigned his privileges rather than await the board's ruling and brought an action against the Partners of the Astoria Clinic for a violation of the Sherman Act as a result of their peer review activities.

Dr. Patrick was successful at the district court level, with the jury finding a Sherman Act violation and damages of $650,000, which the court, pursuant to law trebled to nearly two million dollars.[204] The court of appeals reversed, finding that even though there was

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trust legislation, and that by 1984, nearly half of all health care anti-trust suits were the result of some sort of privilege denial.

[199] 486 U. S. 94 (1988).

[200] Id, at 96.

[201] Id. The Astoria clinic physicians refused to deal with Dr. Patrick professionally, declining to make referrals even when he was the only general surgeon on staff, and often refused to give consultations cover Dr. Patrick's patients when he was away, while at the same time criticizing him for failure to request outside consultations and obtain proper coverage for his patients.

[202] Id, at 97.

[203] Id.

[204] Id, at 98.

substantial evidence of the bad faith of the defendants, they were immune under the state-action exemption to anti-trust liability.[205] The Supreme Court reversed the court of appeals, rejecting the defense of state-action immunity, as the defendant's could not satisfy the two pronged test for establishing state-action immunity. The challenged restraint must be clearly articulated and affirmatively expressed as state policy, and the anti-competitive conduct must be actively supervised by the state itself.[206] In this case, the Court ruled that the active supervision test was not met.[207]

The Court held that the active supervision requirement mandated that the state exercise ultimate control over the challenged conduct as a means of assuring that the anti-competitive conduct of individuals actually furthers the state purpose and does not inure solely to the benefit of the private actor.[208] The Court rejected the argument that the state exercised active supervision through its Health Division as that agency merely assures that hospitals have peer review procedures, but does not have any authority with respect to individual peer review decisions.[209] Similarly, the Board of Medical Examiners (BOME) had no authority to review or reverse decisions of a peer review committee.[210] Finally, the Court rejected the argument that judicial review served as active supervision, as review by the Oregon courts would amount to no more than assuring that reasonable procedures were afforded the physician and that there was some evidence from which it could be found that the physician

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[205] 800 F.2d 1498 (1986).
[206] 486 U.S. at 100.
[207] Id.
[208] Id.
[209] Id, at 102-3.
[210] Id.

was a threat to patient safety.[211] This constricted review did not convert a privileging decision into state action for purposes of the immunity of the state action doctrine.[212]

With the *Patrick* decision, two important common-law defenses, the learned profession exemption and the state-action immunity doctrine were no longer available to insulate physicians engaged in peer review from potential liability. As *Patrick* worked its way through the federal courts, Congress recognized the need for comprehensive federal legislation that would address the related problems of increasing instances of medical malpractice and the ability of physicians to move from state to state without some record of previous malpractice.[213] They recognized that effective peer review was the most viable remedy for these problems, but the threat of money damages under federal laws, particularly anti-trust law, served as a strong disincentive to aggressive peer review.[214] The primary purpose of HCQIA was to provide incentive and protection for effective professional peer review.[215]

HCQIA provides qualified immunity from liability for professional review actions to any professional review body, member of such a body, one under contract with such a body or one who otherwise assists the body in its professional review function, provided that the

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[211] Id, at 105.
[212] Id.
[213] 42 U.S.C. 11101.
[214] Id.
[215] Id. The Supreme Court acknowledged the policy argument in favor of such a law, but noted that if the medical profession were to be exempt from the constraints of anti-trust law, it was for the congress to promote such a policy through legislation and not the Court. 486 U.S. 94, at 105.

action follows procedures that meet statutory due process standards.[216] Congress excepted civil rights claims from the immunity and conditioned the immunity on the proper reporting by the professional review body of certain adverse actions to their state boards of medical examiners, or similar agencies, for ultimate reporting to a national data base.[217]

In order to realize the benefit of the immunity, a professional review action must be taken in the reasonable belief that it furthers quality health care; after a reasonable effort to obtain the facts of the matter; after adequate notice and hearing procedures, or such other procedures as are fair under the circumstances; and in the reasonable belief that the action was warranted by the facts known after a reasonable effort to obtain the facts.[218] The adequate notice and hearing requirement is deemed to have been met if the notice advises that a professional review action has been recommended, includes the reasons for the recommended action, and advises the physician of the right to a hearing and the time within which it must be requested.[219] If the physician requests a hearing, they are further entitled to notice of the date, place and time of the hearing as well as a list of anticipated witnesses.[220] The hearing must be before an arbitrator mutually acceptable to the physician and health care entity or an officer appointed by the entity who is not in direct economic competition with the entity or before a panel of individuals who are not in direct economic competition with the physician.[221] The physician has the right to be represented by an attorney or a

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[216] 42 U.S.C 11111.
[217] Id.
[218] 42 U.S.C 11112.
[219] Id.
[220] Id.
[221] Id.

representative of the physician's choice, to a record of the proceedings, to call, examine and cross-examine witnesses, to present relevant evidence regardless of its admissibility in a court of law and to submit a written statement at the close of the hearing.[222] After the hearing, the physician is entitled to the written recommendation as well as an explanation of the reasons that formed the basis of the recommendation and the written decision of the health care entity, also to include the basis for its decision.[223]

The enactment and provisions of HCQIA offer perhaps the strongest support both for providing procedural protections to physicians facing adverse peer review actions and for eliminating the distinction between public and private hospitals. The benefit of the immunity offered by HCQIA alone ought to be enough to encourage all hospitals to offer procedural protections to physicians by choice . However, the degree to which HCQIA both acknowledges and promotes the major role of peer review in regulating the quality of health care, a traditional state function, supports the grant of procedural due process as a matter of law. The clearest example of the dovetailing nature of peer review with the state function of assuring quality of care are the reporting requirements of HCQIA, as well as those of most states, with respect to adverse privileging actions. Many states require hospitals to report significant adverse privileging actions to the state board or agency responsible for licensing physicians as a condition of licensure for the hospital. [224] The HCQIA directs any health care

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[222] Id.

[223] Id.

[224] See, e.g. 42 U.S.C.S. 11133-11134 (1997); Cal. Bus. & Prof. Code 805 (1996); O.C.G.A. 31-7-8 (1996); Code of Ala. 34-24-360 (1996) (The legislature declared that removal of staff privileges alone is sufficient grounds for revocation of state licensure); Alaska Stat. 08.64.336 (1996); Mass. Ann. Laws, ch 112 section 5B (1996); Miss. Code Ann. 73-25-83 (1996).

entity which takes an adverse privileging action which will last longer than thirty days, or which accepts the surrender of clinical privileges of a physician under investigation in return for terminating the investigation, to report such action to the Board of Medical Examiners, or some similar agency as designated by the Secretary.[225] The failure to report such adverse actions could result in the loss of the protections afforded to health care entities under HCQIA, as well as compromise the license of the health care entity.

The debate as to whether the privileging activity of private hospitals should be subject to the same law as public hospitals has usually focused on such issues as the receipt of public funding via government sponsored health care programs and hospital construction programs[226] or the degree to which the state regulates all hospitals.[227] A substantial majority of jurisdictions as well as the United States Supreme Court rejects the argument that this degree of governmental entanglement is sufficient to render what would otherwise be private activity state action sufficient to confer an entitlement to fourteenth amendment due process rights.[228] However, the involvement of both federal and state governments in the shaping of peer review procedures and hearings, as well as the oversight exercised via the reporting requirements is far greater than the mere funding and general regulation of hospitals. Protecting the public from incompetent physicians is very much a traditional state function, but it is conceded that the boards are typically overwhelmed by the demands and serve as a reactive and limited agency. Their dependence on the peer review process, and, in some

[225] 42 U.S.C.S. 11133(a).
[226] See Seimetz, supra note 40; Quinn, supra note 124.
[227] See, e.g. Greisman v. Newcomb Hospital, 192 A.2d 817 (New Jersey 1963)..
[228] Rendell-Baker v. Kohn, 457 U.S. 830 (1982); Blum v. Yaretsky, 457 U.S. 991 (1982).

cases, the great deference shown to the decisions of those bodies is very much a delegation of that responsibility. This is best typified in the purpose statement of the HCQIA which notes that peer review is the most vital tool in dealing with a national crisis of medical malpractice. This is explicit recognition that governmental agencies have a dependent and in some ways subordinate role in this enterprise. Given the current status of peer review and its role in regulating physician conduct and competence, it is not unreasonable to suggest that peer review activities of private hospitals should be treated as state action and minimal due process protections be afforded to physicians facing adverse privileging action.

Part IV

How Much Process is Due

Granting minimal procedural due process protections in privileging hearings without distinction as to the status of the hospital by no means signals a surrender of all control of the hearings to respondent physicians or their counsel. The entitlement to due process need not result in an oppressive, time consuming exercise which elevates procedure over substance. It is certainly possible to provide sufficient procedural rights to afford a fair hearing and proper results while at the same time managing those aspects of the process that participating physicians find most unattractive. There are far too many benefits to all parties by affording procedural due process to fall below that standard. The most important is that by front-loading the procedural protections at the hearing stage, it becomes possible to avoid litigation

farther down the road. The following sections address some of the more contentious areas of procedure in privileging hearings.

1. Standards for privileging

Two closely related but conceptually different issues are the general standards which a hospital may set for the granting and maintenance of privileges, and the notice of charges a hospital is required to provide a physician when it seeks to take adverse privileging action against that physician. Each issue relates to the degree of specificity a hospital must achieve when notifying a physician there has been a recommendation for adverse action. Adequate notice is one of the fundamental elements of due process. If a physician is to be afforded a fair hearing he must be able to prepare a response which refutes the evidence to be presented and to prepare and present evidence in his favor which specifically tends to establish that he is a reasonably competent physician.

Often, the bylaws of a hospital will refer to standards of personal behavior that a physician must meet in order to be granted and maintain privileges.[229] The procedural inadequacy often cited by respondent physicians is that the conduct in question in no way relates to the quality of care rendered by the physician, and, therefore, the adverse action does not promote a legitimate hospital interest.[230] In the case of *McElhinney v. William Both Memorial*

[229] McElhinney v. William Booth Memorial Hospital, 544 S. W. 2d 216 (Ky. 1976).
[230] Id.

Hospital[231] the Supreme Court of Kentucky ruled on a case in which a physician's privileges were revoked.[232] The applicable staff bylaw indicated that the grounds for revocation included a "violation of sufficient gravity to warrant such action."[233] The court found the plaintiff to be a good physician, describing the evidence as revealing "an especially competent, dedicated and busy surgeon whose prime concern is the welfare of his patients and the improvement of hospital conditions."[234] There was not a "scintilla" of evidence of negligence or incompetence in the care of his patients, nor was there any aspect of conduct in his personal or professional life that was a threat to his patients.[235] The court did observe that the plaintiff cut a rather wide swath of criticism across several departments and his rather assertive identification of the shortcomings of others was actually the basis of the revocation of his privileges.[236] The court ordered the reinstatement of plaintiff's privileges, but expressed no opinion as to the general validity of a reasonably definite standard which required an ability to work in harmony with others.[237] Rather, the court held that a hospital cannot revoke staff privileges absent a sufficiently definite standard which proscribes the conduct for which the revocation is adjudged.[238] The fact that a doctor cannot get along with some other physicians due to his criticism of their care is not sufficient grounds, as a matter of law, to revoke his privileges.[239]

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[231] 544 S. W. 2d 216 (Ky. 1976).
[232] Id.
[233] Id, at 218.
[234] Id, at 217.
[235] Id.
[236] Id, at 217-18.
[237] Id, at 218.
[238] Id.
[239] Id.

The case of *Miller v. Eisenhower Medical Center* [240] also addressed the issue of basing a privilege revocation on the poor interaction between the challenged physician and the rest of the hospital staff. It is an almost universal standard for membership on a medical staff that a physician demonstrate an ability to work well or get along with others,[241] and the courts have fairly uniformly upheld the general validity of such bylaws.[242] In the *Miller* case, the plaintiff was denied staff privileges as written references which he provided referred to his somewhat tempestuous interactions with other physicians, although there was no indication that the quality of his care was anything other than excellent.[243] The specific bylaw on which the hospital relied conditioned the grant of privileges on, among other things, documentation of "their ability to work with others, with sufficient adequacy to assure the Medical Staff and Board of Trustees that any patient treated by them in the hospital will be given a high quality of medical care."[244] It appears that in addition to his poor relationship with other physicians, he had also written a letter of protest condemning the construction of the Eisenhower Medical Center five years earlier in which he made some extremely insulting references to the individuals who were pushing for the construction.[245]

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[240] 27 Cal 3d 614, 614 P. 2d 258 (1980).
[241] Seimetz, supra note 40, at 498.
[242] Mahmoodian v. United Hospital Center, 185 W. Va. 59, 404 S.E. 2d 750 (1991); Lipsett v. University of Puerto Rico, 637 F. Supp 789, 809 (D.P.R. 1986); Robbins v. Ong 452 F. Supp. 110, 115 (S. D. Ga 1978); McMillan v. Anchorage Community Hospital, 646 P. 2d 857, 865 (Alaska 1982); Even v. Longmont United Hospital Association, 629 P. 2d 1100 (Colo. Ct. App. 1981); Silver v. Castle Memorial Hospital, 53 Haw. 475, 479, 497 P.2d 564, 568; Yarnell v. Sister of St. Francis Health Services, Inc., 446 N.E. 2d 359, 363 (Ind. Ct. App. 1983).
[243] 27 Cal. 3d 614, 620.
[244] Id, at 621.
[245] Id, at 623.

The *Miller* court essentially agreed with the *McElhinney* court in holding that even a private hospital may not adopt a standard for staff membership which is so vague as to invite exclusion on an arbitrary or irrational basis nor one which is contrary to public policy.[246] However, the court drew a distinction between an "ability to get along with others" and an "ability to work with others."[247] The latter, the court held, implies an ability to cooperate in the performance of hospital functions as opposed to a generic ability to achieve compatibility with one's colleagues.[248] Thus, the valid application of such a bylaw requires some evidence of a nexus between the ability to work together and the delivery of high quality patient care, as the bylaw demands.[249] It is not enough to demonstrate that the physician is roundly disliked and others would find it unpleasant to work with him. Although the bylaw was not invalid on its face, the court placed the responsibility on the hospital to demonstrate that the inability to work with others presents a real and substantial danger to patients who might be admitted by the physician.[250]

The holding and reasoning of the California Supreme Court in the *Miller* case has been criticized for failing to achieve the objective of establishing a standard by which to measure bylaws calling for harmonious relations as a condition of privileges.[251] They failed to articulate how the burden of establishing a nexus between the poor personal interactions of a

[246] Id, at 626.
[247] Id, at 627.
[248] Id, at 628.
[249] Id.
[250] Id, at 629
[251] Seimetz, supra note 40, at 497.

physician and a negative impact on patient care is to be met.[252] The court only noted that the medical executive committee failed to state clearly that the inability of plaintiff to work well with others would negatively impact on patient care.[253] The criticism of the decision is that it may be perceived to imply that the burden may be satisfied by as little as an affirmative finding by an appropriate committee that the physician's conduct would so affect patient care. The case of *Pick v. Santa Ana-Tustin Community Hospital*[254] is cited by critics as reflective of the failure by the court to demand that a bylaw identify specific prohibited conduct or that a peer review committee identify specific instances in which patient care was affected.[255] The plaintiff was denied privileges as his demonstrated inability to get along with others was such that it would present a real and substantial danger to patients treated by him and they might receive other than a high quality of medical care.[256] Plaintiff challenged this, and apparently some critics agree, as nothing more than a conclusory statement not supported by the evidence in the record.[257] Although the court agreed with plaintiff that a mere finding of an abrasive personality and an inability to get along with others was not sufficient for denial of privileges, they noted that the essential finding of the executive committee was that the inability to get along would present a real and substantial danger to his and other physicians' patients, thereby satisfying the *Miller* standard.[258] The weakness in the *Miller* rule asserted by its critics is that the hospital's adverse decision will survive scrutiny as long as they use some combination of words that suggests they found that the

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[252] Id.
[253] Id.
[254] 130 Cal. App. 3d 970, 182 Cal. Rptr. 85 (1982).
[255] Seimetz, supra, note 40, at 497.
[256] 130 Cal App. 3d at 977.
[257] Id, at 976.

physician's failure to meet an otherwise vague standard is the type of failure that will ultimately harm patients.

This criticism is misplaced and misperceives the need and purpose for such a bylaw. The substance of the criticism and the judicial challenges to such bylaws is that by avoiding articulated and objective standards, a hospital may deny privileges based on criteria that are completely malleable, meaning different things to different people. If a hospital does not have to define in advance what sort of conduct affects patient care, then subjective criteria leading to unreasonable decisions is the inevitable result. This criticism ignores the reality of the difficulty of defining the standard and the potential negative impact of establishing such self-limiting criteria. One must agree that there is a potential for the peer review process to be corrupted and used as a means of settling scores or punishing vocal critics. On the other hand, it cannot be denied that the behavior of some physicians and the personality conflicts with other hospital and medical staff can be so disruptive that patient care is compromised.

The infinite variety of behaviors that could impact on hospital care and the infinite gradations in which they could occur make it completely unreasonable to suggest that in order to enforce a bylaw requiring good working relationships the hospital must define those behaviors and the circumstances under which they could harm patients. The same behavior in one setting, as in the *McElhinney* case, could be lauded as a near quixotic attempt to force improvement in patient care, while in another setting it could be so unreasonable and widespread as to create an atmosphere of distrust, dissension and poor communication, with

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[258] Id, at 977

the patients caught in the crossfire of sniping physicians. Similarly, identifying, reporting and addressing substandard care is the essence of peer review and vital to assuring the highest quality of care. It would be a bitter irony to use a peer review mechanism to punish good faith efforts to improve care. However, the degree of criticism, although justified, may be so extreme in some cases, and taken so far out of the normal peer review channels as to constitute unprofessional behavior and ultimately both impede the process of peer review and harm patient care.

The answer to this uncertainty is not to do away with this type of bylaw or to force such specificity in promulgating them that they become meaningless. Clearly, in order to satisfy the requirements of constitutional due process or the common law demand of fundamental fairness, the behavior which forms the basis for terminating privileges must be related to patient care. It is enough that the bylaw establish this requirement in a general way. Such bylaws ought to be praised for their flexibility and not attacked for their vagueness. These bylaws do not raise issues of vagueness, rather the issue is one of evidentiary sufficiency. The California Supreme Court did not enunciate a standard so easily satisfied that all a hospital must do is declare a nexus between the conduct in question and patient care. In fact the court specifically rejected the suggestion that certain conduct is so inherently disruptive that it conclusively can be found to harm patient care.[259] Rather, the court imposed an

[259] 27 Cal. 3d 614, 629. The court rejected the holding in Huffaker v. Bailey, 273 Ore. 273, 540 P. 2d 398 (1975) that a physician's ability to work with others has an inherent effect on patient care and that in all cases where such a reduction in ability is shown the court must sustain the hospital's decision absent a showing of manifest abuse.

affirmative duty on the part of the hospital to demonstrate, presumably through some evidence, the nexus between the physician's behavior and patient care.[260]

The case of *Mahmoodian v. United Hospital Center* [261] stands as a good example of the necessity of such bylaws and the proper application of the *Miller* standard.[262] The plaintiff challenged the revocation of his privileges, alleging the bylaws on which the revocation was based were impermissibly vague.[263] One hospital bylaw prohibited conduct considered to be disruptive to the operations of the hospital, and another conditioned privileges on an ability to work with others so as to assure that any patients treated by the physician will receive a high quality of medical care.[264] The court, citing the standard in *McElhinney*, ruled that such bylaws were not impermissibly vague.[265] However, plaintiff also asserted that even disruptive conduct could not be the basis for a privilege revocation absent a substantial and specific threat to patient care from that conduct.[266] The court cited with approval and joined the majority of jurisdictions which hold that a hospital may adopt and enforce such bylaws when the inability to work or get along well with others may have an adverse overall impact on patient care.[267] However, the court noted that the adverse impact could not be presumed

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[260] Id.
[261] 185 W. Va. 59, 404 S.E.2d 750 (1991).
[262] The case of Pick v. Santa Ana-Tustin Community Hospital, 130 Cal. App. 3d 970 is not the aberration described by its critics. The court cited several instances in which the hospital relied upon specific instances in which plaintiff's inability to work with others had negatively impacted on patient care.
[263] 185 W. Va. 59, 67.
[264] Id.
[265] Id.
[266] Id.
[267] Id, at 68. The court also adopted the rule that the disruptive conduct was sufficient to justify adverse privileging action if it was found that such conduct may or could adversely affect patient care, rejecting the minority view that the hospital must show that the disruptive conduct probably will have an adverse impact.

"but must be shown by the evidence."[268] The court also noted that a physician may be so disruptive as to throw the hospital or a substantial portion of it into turmoil, leading the hospital authorities to perceive an overall threat to patient care.[269] Thus, this court, unlike the *Miller* court did not require a finding of a "specific" threat to patient care.

In spite of that aspect of the holding that seems to have excused the hospital from showing a specific threat of harm, as opposed to a general overall threat to patient care, it appears that the evidence offered to demonstrate the possibility of harm may have risen to that level at any rate. The court cited one incident in which plaintiff believed another physician was performing a surgical procedure for which he was not privileged, and, rather than following proper procedures, strode into the operative suite in the middle of the procedure and demanded it be halted. The court noted the obvious threat to patient safety.[270] The court also cited plaintiff's practice of refusing to give verbal orders to registered nurses, as he was feuding with them, and to give the orders instead to licensed practical nurses who were not authorized under hospital policy so to take orders. This required that one of the registered nurses to whom he was willing to speak call him formally to receive the order.[271] Again the threat to patient care from delayed orders is patent.

It is readily apparent from the cases addressing this issue that the courts will support the effort to revoke or deny privileges to physicians before their disruptive conduct demonstrably

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[268] Id, at 70.
[269] Id.
[270] Id, at 71.
[271] Id, at 72.

harms patients. To require proof of specific threats to particular patients is untenable as it would put patients in harm's way to protect the interest of physicians in having a more definite standard against which they will be evaluated. There is no question that the non-specific nature of the bylaws leaves the merely irascible, unpopular physician exposed, but the threat is not based on the vagueness of these bylaws. It emanates from allowing the bylaw to be applied without the requisite showing that the complained of conduct does, in fact, pose a realistic threat to patients. As the *Mahmoodian* case aptly demonstrates, evidence of the physician's disruptive conduct placed in the context of actual events, rather than some abstract description of conduct divorced from its context, is the best evidence of potential harm to patients. Similarly, as the *Miller* and *Posner* cases aptly demonstrate, placing the allegedly disruptive conduct in its true context often works to the benefit of the aggrieved physician. It often reveals that the true purpose of the recommended adverse action may have been to punish the physician rather than to promote patient care. Simply measuring the degree to which the conduct matches some specific prohibition under the bylaws would not have assured the same result as actually examining the underlying circumstances of each case.

The goal and responsibility of the hospital should not be to protect physicians by more artful but self-limiting drafting of the bylaw nor by eliminating them entirely. This would certainly not serve the interests of patients. Hospitals would be better advised to concentrate on properly documenting incidents in which the conduct of physicians could harm patients. Although specific instances of harm are not required, it would be most useful, as in *Mahmoodian*, to demonstrate how the poor relationship between the physician and the other

staff manifests itself. What are the results in terms of its effect on patient care, even if no specific adverse outcomes can be attributed to a particular instance of hostile or disruptive behavior. It is also critical for the leadership of the hospital staff, including hospital counsel, to recognize when they are dealing with a situation in which a highly critical physician or one with an otherwise unpleasant personality has been targeted for termination by way of privileging action and when they are dealing with a situation in which a physician's inability to work with his colleagues is such that it threatens patient safety.

2. Notice of charges

Notice of a hearing prior to the deprivation of a property interest is considered to be one of the fundamental elements of procedural due process. However, notice in the context of privilege hearings has come to mean more than merely communicating the time, date and location of the hearing. It also requires a description of the acts or omissions which form the basis of the recommendation for adverse action with enough specificity to allow the physician to prepare a defense of the charges.[272] In cases in which the competence of the physician is called into question, the issue with respect to adequacy of notice usually centers on whether the physician was advised of the specific cases in which he provided substandard care and whether he was advised of the specific acts or omissions which comprised the substandard

[272] Yashon v. Hunt, 825 F.2d 1016 (6th Cir. 1987); Marin v. Citizen's Memorial Hospital, 700 F. Supp. 354 (S.D. Tex. 1988); Anton v. San Antonio Community Hospital, 19 Cal. 3d 802, 567 P. 2d 1162, 140 Cal. Rptr. 442 (1977); Rosenblit v. Superior Court, 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (Cal. App. 4 Dist. 1991).

care.[273] The spectrum of competing philosophies is wide. At one end is the belief that a hospital need only provide a simple general description of the areas of incompetence and, if they choose, a list of the names of representative cases that support the general allegations.[274] At the other end is the belief that each allegation of incompetence must be specific and must be accompanied by specific cases, along with a description of the specific acts or omissions in each one that constitutes the substandard care.[275]

One of the underlying principals of procedural due process which controls the degree of specificity required is that informal proceedings, such as privileging hearings, need not be conducted as full blown trials.[276] That principle has been applied in cases that hold the charges in privileging hearings need not be so specific as to amount to the pleading of evidence.[277] In *Woodbury v. McKinnon,*[278] plaintiff faced four allegations; (1) lack of competence and judgment to perform surgical procedures; (2) lack of an assistant while performing surgery; (3) assisting another who had no surgical privileges, and; (4) training and background.[279] Names and records pertinent to the first three charges were provided, but when plaintiff requested the exact nature of the fault in each case, hospital officials refused to be more specific, believing that the records themselves would reveal to any competent physician the nature of the failing.[280] The court upheld the hospital's choice not to match each case to a specific allegation, noting that their only concern was whether sufficient notice

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[273] Rosenblit v. Superior Court, 231 Cal. App.3d 1434, 1445.
[274] Woodbury v. McKinnon, 447 F. 2d 839, 843-44.
[275] Rosenblit v. Superior Court, 231 Cal. App. 3d 1434, 1445.
[276] Christhilf v. The Annapolis Emergency Hospital Association, 496 F.2d 174, 179 (4th Cir. 1974).
[277] Truly v. Madison General Hospital, 673 F. 2d 763 (5th Cir. 1982).
[278] 447 F. 2d 839.

was given to satisfy the minimum demands of due process and not "whether the charges would survive the scrutiny applied to a criminal indictment."[281]

Another line of cases seems to suggest that a general description of the charges or complaints regarding the physician will suffice if the specific instances underlying the charges are well known to the physician.[282] In *Truly v. Madison General Hospital,*[283] plaintiff alleged that two of several bases for revocation were not sufficiently specific to satisfy the demands of due process. He was accused of being inaccessible to patients and employees after hours and during times of crisis and it was alleged that he would probably be unable to get along with the administration given his history of severe public criticism of the hospital, but no specific instances giving substance to these allegations were included in the notice.[284] The court observed that the notice given plaintiff concerned his own recent activity and the allegations should have easily called to his own recollection those activities.[285]

This line of reasoning has been applied to charges of poor patient care as well. In *Yashon v. Hunt,*[286] plaintiff insisted he was entitled to a detailed written statement of the grounds for

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[279] Id, at 844
[280] Id.
[281] Id. It should be noted that this case has been characterized as remarkable for its casual perception of the due process requirements. See, e.g. Groseclose, supra note 120, at 6. The court, among other rulings, held that due process does not even require an opportunity to cross examine witnesses. Although this ruling is questionable and the case is admittedly dated, it is still cited with approval for its ruling regarding adequacy of notice. See, e.g. Adkins v. Sarah Bush Lincoln Health Center, 129 Ill. 2d 497, 544 N. E. 2d 733 (1989).
[282] Truly v. Madison General Hospital, 673 F.2d 763, 766.
[283] Id.
[284] Id.
[285] Id.
[286] 825 F. 2d 1016.

the recommended adverse action, to include specifying the cases in which his care was questioned and stating with reasonable completeness the nature of the criticism in each case.[287] The court rejected this argument, noting that plaintiff was already aware of all but one of the charges, as they were the subject of prior disciplinary proceedings against him, and, under such circumstances, written notice of specific charges was not necessary.[288] In the case of *Marin v. Citizens Memorial Hospital,* [289] the court took the analysis one step further. In that case the hospital violated its own bylaws by failing to include in the notice of the hearing specific charges and the medical charts being questioned.[290] Nevertheless, the court noted that three of the four cases had previously been discussed with plaintiff and the minutes of the meeting reflected that plaintiff was thoroughly conversant with the four cases and discussed them at length, and therefore specific written notice was not required.[291]

In some cases this analysis has been applied to situations in which the physician received little or no specific information other than the list of cases to be considered by the hearing committee and did not necessarily have prior knowledge of the matters under consideration.[292] In *Adkins*, the hospitals bylaws required notice of a privilege hearing to state in concise language the acts and omissions charged, a list of specific or representative

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[287] Id, at 1025.
[288] Id. The court cited Woodbury v. McKinnon with approval also holding that in such informal hearings notice need not rise to the level necessary to support a criminal indictment. It is thus unclear whether the court would also have found due process satisfied if the specific cases were not already known to plaintiff from prior proceedings.
[289] 700 F. Supp. 354 (S. D. Tex. 1988)
[290] Id, at 358.
[291] Id. The court also held that if a hospital bylaw offers more procedural protection than the minimum required under constitutional due process, then the failure to comply with the bylaw is not a constitutional violation unless the hospital also fails to meet that standard.

charts being questioned, and any other reasons or subject matter underlying the adverse recommendation.[293] Plaintiff was charged with violating the standard of care for patients at the hospital and with violating restrictions on his privileges and failing to rectify past identified deficiencies.[294] He was provided with the thirty charts the committee was to consider, but apparently the specific problem with each chart was not provided.[295] In other words, the charts were neither matched to particular allegations, nor was the specific deficiency in each case identified. The court considered this sufficient notice, partly basing their decision on the fact that plaintiff was granted an additional month to study the charts and that he testified for over thirteen hours on issues raised in the charts.[296] From this the court determined that plaintiff was able to identify the deficiencies and that he was well prepared to discuss the issues that the cases might raise.[297] Thus, the physician's own comprehensive and competent defense of his care was relied on to demonstrate the adequacy of his notice.

At the other end of this philosophical spectrum is the belief that the statement of charges must, in fact, include specific references to each case file to be considered and state with exactness the precise acts or omissions in that case which were substandard or otherwise problematic. The case of *Rosenblit v. Superior Court*[298] is notable for this proposition. In this case, the hospital provided the challenged physician with a list of thirty charts in support

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[292] Adkins v. Sarah Bush Lincoln Health Center, 129 Ill 2d 497; Knapp v. Palos Community Hospital, 125 Ill. App. 3d 244, 455 N.E.2d 554 (1984).
[293] 129 Ill. 2d, at 514.
[294] Id.
[295] Id, at 515.
[296] Id.

of the charges that Dr. Rosenblit was deficient in the areas of fluid management, diabetic management and clinical judgment.[299] In spite of repeated requests for specific reviewer comments on the thirty charts, the hospital did not comply.[300] Rather, they simply numerically listed the cases without any indication as to which deficiency applied.[301] After observing that the entire course of proceedings had "a notable stench of unfairness," [302] the court ruled that the notice was inadequate.[303] It is worth noting that the hospital raised as a defense to this particular allegation of procedural unfairness that plaintiff, in fact, made a very thorough defense of the thirty cases, thereby proving he had adequate notice.[304] The California Appellate Court, unlike the Illinois Court in *Adkins*, rejected this argument as "backward" and "disingenuous."[305] The court replied that plaintiff had no choice but to prepare a wholesale defense of the cases to meet all possible charges and it is impossible to speculate on how he would have defended his care had he been informed of the exact problem in each case.[306]

A review of some of the applicable statutory mandates for adequate notice to a physician of the bases for a recommended adverse action does little to settle the issue. The HCQIA conditions its grant of qualified immunity on a health care entity meeting certain procedural

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[297] Id.
[298] 231 Cal. App. 3d 1434, 282 Cal. Rptr. 819 (1991).
[299] 231 Cal App. 3d, at 1438.
[300] Id.
[301] Id, at 1446.
[302] Id, at 1445.
[303] Id, at 1446.
[304] Id.
[305] Id.
[306] Id.

standards for its professional review actions.[307] Those standards require, among other things, that the professional review action be taken after adequate notice and hearing procedures or such other procedures as are fair to the physician.[308] HCQIA defines adequate notice as notice that states the "reasons for the proposed action."[309] The statute makes no demand with respect to the form the notice must take nor whether specific cases even need to be included, let alone whether the specific act or omission in each case must be part of the notice. In fact, HCQIA conspicuously lacks any requirement that the physician has a right to the evidence to be presented to the hearing committee.[310] California mandates written notice to any physician facing peer review action that must be reported to the state.[311] Such notice must include "The reasons for the final proposed action taken or recommended, including the acts or omissions with which the licentiate is charged."[312] Although this statute could be read to require that notice must include a representative list of cases with specific acts or omissions identified in each case, it does not explicitly so state. Although the facts in *Rosenblit* occurred prior to the passage of Section 809.1, the decision occurred after its enactment and purports to be based on common law principals.[313] Thus, California likely still requires hospitals to provide physicians with a detailed description of the specific problem in any case which is to be presented to a peer review committee.

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[307] 42 USCS 11111 (a)(1) 1997.
[308] 42 USCS 11112 (a)(3) 1997.
[309] 42 USCS 11112 (b)(1)(A)(ii).
[310] Se 42 USCS 11112 (b)(1)-(3).
[311] Cal. Bus. & Prof. Code 809.1 (c)(1) (1996).
[312] Id.
[313] 231 Cal. App. 3d at 1445.

Clearly, if a physician is to be disciplined on the basis of substandard care, as evidenced by certain enumerated representative cases, then knowledge of the specific acts or omissions thought to have been substandard in those cases is more than a mere convenience.[314] In a complex case involving a lengthy hospital stay, it may be nearly impossible for a physician to ferret out which allegation of incompetence, even from a specific list of allegations, is represented by a particular case. Although the practice of providing written notice of specific charges and then providing a list of representative cases without matching each case to a particular allegation may pass constitutional scrutiny, it is not necessarily a good practice. Placing unnecessary obstacles in the way of a physician who is otherwise entitled to a fair hearing does not promote a valid outcome. Simply making it more difficult for the physician to defend his care or simpler for the hospital to prove deficiencies does not assure that incompetent physicians will more likely be identified and purged.

However, the demand for an unwieldy degree of specificity of allegations has the potential to make it unnecessarily difficult for the hospital to prove that a physician has provided substandard care. Adequate notice can easily cross over from providing a respondent with a meaningful opportunity to defend himself to providing respondent's counsel with a tremendous tactical advantage. The greater the degree of specificity in the allegation of incompetent care in a particular case, the more targeted and specific must be the proof offered by the hospital. While the stated goal of particularized notice with respect to the case files is to allow the physician to refute an allegation of substandard care without having to guess where the fault lay, a secondary, or perhaps primary, goal of defense counsel is to

[314] Truly v. Madison, 673 F. 2d 763, 766.

place a limit on how the hospital may prove that the care in a given case was incompetent. The argument would follow that, as a matter of due process, even if there were other specific acts or omissions that support an allegation of incompetent care, the hospital has lost the opportunity to present such evidence as they failed to include those acts in their notice. Thus, if the physician is able to rebut the specific allegation, even though there are other bases sufficient to support a finding of substandard care, he will argue that he is entitled, as a matter of due process, to a presumption that the standard of care was met.

One commentator has argued that the *Rosenblit* decision mandates not only that the hospital tell physicians what aspect of their patient care is questioned, but suggests that hospitals ought to tell the physician why it is questioned.[315] That is the hospital must not only identify care that is considered substandard, but tell the physician what was wrong with it. Among the proposed criteria which the notice should be required to meet are a description of the resulting negative impact on the patient's outcome. This should include the reviewing entity's opinion of the patient's expected outcome absent the alleged negligent act or omission and how the outcome differed because of the act or omission.[316] The commentator views this as a reasonable approach as it comports with the law of California regarding proof in medical malpractice cases.[317] Further, the notice should include the objective standard of preferred treatment to which the physician's care is being compared, including citations to relevant medical publications which support the purported preferred

[315] Rosen, supra, note 7, at 386.
[316] Id, at 386-87.
[317] Id.

care.[318] Finally, the hospital should be required to describe a proposed plan of corrective action, ranging from education to restriction of privileges.[319]

The above described philosophy and proposals may be the quintessential example of the "lawyerization" of the peer review process, or elevating procedure over substance. Demanding notice that closely resembles a criminal indictment or even the pleadings of a civil trial certainly assures the maximum protection for physicians, but it invites sacrificing the goal of improved quality of care for procedural fairness. It may be appropriate in a criminal trial for a prosecution to fail because of technically inartful drafting of pleadings or the failure of proof of a single element of an offense, but the goal of peer review and the public interest in quality care is not furthered by the application of such a legal standard.

The hospital should seek to strike a balance when providing a physician with notice of a recommended or proposed adverse action. If the hospital intends to rely on representative cases to support a particular charge of a negligent act or omission, from among more than one such charge, it ought to notify the physician which charge is demonstrated by the particular chart. In addition, the charge should be specific enough so that a reasonably competent physician who is reviewing the record or who was involved in the incident can identify the concern of the medical staff.[320] In the *Rosenblit* [321] case it would have been a simple matter for the hospital to notify plaintiff which of the thirty cases that were to be

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[318] Id, at 387.
[319] Id.
[320] Kadzielski, supra note 105, at 151.
[321] 231 Cal. App. 3d 1434.

submitted to the committee were examples of poor fluid management and which were examples of poor diabetic management. The benefit to the physician in terms of efficiently preparing for the hearing is enormous and it costs the hospital little to be so specific. In fact, the efficiencies of such an approach inure to the benefit of the hearing committee as well. One of the more unpleasant aspects of peer review is the sacrifice of time by the participants.[322] The courts in *Rosenblit* and *Adkins* noted that the general nature of the charges and the failure to specify the deficiency in each chart resulted in lengthy defenses by the physician. Although the courts differed with respect to the legal merits and significance of this fact, the practical impact on the hearing process is the same. The committee must wade through the entire chart to determine what was wrong with the care, unless they receive in evidence pertinent testimony or documents directing them to the problem. In addition, they must also listen to lengthy defenses that are not focused on the specific problem in issue. All that can be done to streamline the hearing process without sacrificing thoroughness or procedural fairness should be done.

On the other hand, some degree of breadth and generality in the drafting of charges provides certain benefits to the peer review process as well. Some flexibility in the presentation of the evidence and the range of findings by the committee members is one benefit. The charges should not be so specific that subsequently discovered relevant evidence will be excluded.[323] Similarly, they should be sufficiently general so that varying opinions as

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[322] See footnote 82 supra and accompanying text.
[323] Kadzielski, supra note 105, at 151.

to the precise nature of the deviation from the standard of care can be introduced.[324] The same physician who reviewed the care in question and found it poor enough to warrant adverse action may not be the witness discussing the case at the hearing.

Once again, the *Rosenblit* case offers a good example. Under the philosophy favoring a high standard of specificity, the hospital would not only have had to identify each case as an example of poor fluid management or poor diabetic management (a reasonable standard), but would also have to explain precisely how fluid management was mishandled. In other words, the hospital would have to notify the physician which order for intra-venous fluids was inappropriate and why. Such issues as whether it was generally inappropriate, or inappropriate at that particular time for that particular patient would have to be clarified. In addition, the notice would have to identify the negative impact on the outcome, along with a description of the expected outcome and the care which could have reasonably been expected to achieve that result.

Although such specificity would certainly help in the preparation of a defense, it is simply not required under due process or fundamental fairness. This approach would turn a privilege hearing into a series of malpractice cases. In each case the hospital's proof would be limited to that which it included in the notice to the physician. This approach may be appropriate for a judicial proceeding but it is not appropriate to apply all the standards of a judicial proceeding to the medical staff process of determining the quality of care rendered by a colleague. Demanding this level of notice is a highly constrained and artificial approach

[324] Id.

antithetical to the way in which medical, as opposed to legal truths are determined. The review of a particular case typically involves the same gestalt type approach as treating the patient. Treatment decisions are not made in discrete measurable components, and neither is the review of a case. It should be enough to tell a physician that he took an inadequate history and physical without specifying how, or that he used poor infection control techniques without describing how his treatment varied from acceptable infection control techniques. This principle is reflected in those cases in which the courts have held, in agreement with the hospitals, that it should be enough for a competent physician to be told of the general failing in a case for that physician to identify on review of the chart the precise nature of the reviewer's concern.

3. Discovery

a. The case for a general right of access to relevant materials

The issue of a physician's access to the evidence to be submitted against him is another frequent subject of contentious debate. The physician naturally desires to have access to all of the damaging information which formed the basis of the recommended adverse action and which will likely be presented to the hearing committee. In addition, the physician would likely find relevant material in the hospital's possession that the hospital does not intend to submit or use at the hearing, but which could prove useful to the physician's case. This issue

is closely related to the broader concept of the privilege and confidentiality with which peer review materials are otherwise cloaked.

Once again both HCQIA and California's privilege hearing statute address the issue of discovery. HCQIA includes among its requirements for adequate notice and hearing that the physician be advised of the reasons for the proposed adverse action[325] and a list of witnesses (if any) who will be testifying at the hearing.[326] In addition, HCQIA specifies among the hearing rights enjoyed by the physician the right to present evidence determined to be relevant by the hearing officer without regard to the admissibility of such evidence in a court of law.[327] HCQIA does not expressly require that any particular evidence in the hospital's possession be accessible, nor does it address any discovery mechanism by which to make such evidence available to the physician. It is certainly not clear that the right to know the reasons for a proposed action, to know who will be witnesses against the physician, and the right to present one's own relevant evidence to the committee translate into an obligation on the part of the hospital to open all its potentially relevant medical and peer review records to the physician.

Under the California Code a physician enjoys the right to inspect and copy any documentary information relevant to the charges which the peer review body has in its possession or under its control.[328] The presiding officer, when determining relevance, is

[325] 42 USCS 11112(b)(1)(A)(ii).
[326] 42 USCS 11112(b)(2)(B).
[327] 42 USCS 11112(b)(3)(c)(iv).
[328] Cal. Bus. & Prof. Code 809.2(d).

directed to consider whether the information supports or defends the charges, the exculpatory or inculpatory nature of the information, the burden of granting access and any previous similar requests submitted or resisted by the parties.[329] In addition, each party must exchange witness lists and copies of all documentary evidence that they plan to present at the hearing no later than ten days before the hearing.[330]

It is likely that the lack of a specific requirement for discovery under HCQIA is in deference to and recognition of the fact that most states have enacted statutes that provide an evidentiary privilege for any documents or other materials generated as a result of peer review activities.[331] Given the variety of approaches adopted by the states, it would not have been practical for Congress to define the proper right of access to such materials by physicians. However, when one looks at the rights afforded physicians in the entire context of HCQIA, it would seem that some discovery was presumed to be appropriate. A challenged physician is entitled to present evidence determined by the committee to be relevant, even if not otherwise admissible in a judicial proceeding. This strongly suggests the drafters contemplated a physician having access to materials that would otherwise be protected from discovery or admission into evidence. Another factor arguing strongly in favor of recognizing some right to discovery is that many states provide for a rather comprehensive privilege for peer review materials, but make an exception for access by

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[329] Id, at 809.2(e)(1)-(4).
[330] Id, at 809.2(f).
[331] Pamela McKinney, *The Peer Review Privilege: A Dying Cause?*, 25 J. Health & Hosp. L. 201 (1992).

physicians who are opposing an adverse privileging action either through a hearing or through litigation.[332]

The requirements of due process or a fair hearing and the statutory framework of the states and HCQIA at a minimum appear to call for access to all the documents that the hospital intends to submit to the committee as well as copies of or access to the cases to be submitted.[333] Nearly as strong a case can be made for allowing the physician access to all peer review materials that pertain to him, as well as the treatment records of all the patients he has admitted to the hospital. Weighing the interests of the physician against the burden this creates for the hospital supports this level of discovery. The physician is granted the right or opportunity to present evidence that refutes the specific allegations of substandard care and supports his defense that he is, in fact, a competent physician. This would be a meaningless exercise if the physician were denied access to most of the evidence relevant to his defense. Although peer review hearings are not intended to be adversarial, they inevitably take on that appearance and that tone. It would be difficult to imagine a situation in which it would be considered fair, let alone consistent with due process, to place the entire responsibility in the hands of the hospital for determining which documents in the possession of the hospital are relevant or to be submitted to the committee.

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[332] See, e.g. A.R.S. 36-445.01 (1996); H.R.S. 624-25.5 (1996); Ind. Code Ann. 34-4-12.6-2 (1996); Cal. Evid. Code 1157 (1996).

[333] Among the acts by the hospital in the Rosenblit case which the court found particularly offensive was the persistent refusal by the hospital to provide copies of the thirty representative cases they intended to submit to the board, thereby denying plaintiff's expert an opportunity to review the cases prior to his testimony at the hearing.

The benefits of relatively liberal discovery are not limited to the respondent. The hearing committee is not intended merely to function as an adjudicative body, passively receiving information. They have a fact-finding and investigative responsibility as well. It would be to their benefit to have both sides of the controversy providing information and fully developing the competing viewpoints. One of the more unappealing aspects of peer review is its labor intensive, time-consuming nature. A great deal of efficiency can be added by allowing the challenged physician to discover and present information which the committee might otherwise feel compelled to uncover on its own.

b. Restriction of access to the records of other physicians

The right of discovery, like the need for specificity of charges, can rapidly evolve from a basic procedural right intended to insure fairness to an oppressive function, when exercised through counsel. As with the drafting of the charges, the degree of discovery need not be as expansive as that which might be allowed in a judicial proceeding. The hearing committee should jealously guard the responsibility for determining relevance and jealously protect the privileges and confidentiality which inure to the hospital. It is not an unusual defense for a physician to claim that his care or his behavior is no worse than that of other physicians against whom no action has been taken. From this, the respondent argues adverse action recommended in his case is not motivated by the reasonable belief that it will improve patient care, but rather is motivated by animosity or some other inappropriate reason.[334] In order to

[334] See, e.g. Woodbury v. McKinnon, 447 F.2d 839; Smith v. Ricks, 31 F.3d 1478; Peterson v. Tuscon General Hospital, Inc., 114 Ariz. 66, 559 P. 2d 186. This author's personal experience in due process

support this defense, physicians will insist on access to the peer review records of their colleagues as well as the medical records of the patients they have treated.

One of the earliest cases dealing with this issue was *Woodbury v. McKinnon.* [335] Plaintiff's surgical privileges were revoked by the hospital and he sued claiming deprivation of procedural and substantive due process. He complained that his attorney was denied the right at the time of his privilege hearing to cross examine or question the physicians serving on the committee, nor could he question them by deposition or interrogatory at the time the case was heard by the district court.[336] Plaintiff alleged that such discovery would have shown that his surgical judgment and his procedures were as good or better than those of other staff and the rules and regulations he was accused of violating were also violated by the same staff members who would determine his surgical privileges.[337] Plaintiff's position was that inasmuch as his skills were being considered by other hospital staff members, their skills too must be subject to scrutiny.[338] The court rejected this argument, holding that the right to make such a challenge was not constitutionally required.[339] In addition, the court held that the claim of disparate treatment would add little support to his constitutional claim. Absent some evidence of intentional or purposeful discrimination, and where a facially reasonable

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hearings is somewhat limited, but of the several in which the author has been involved, the respondent physician has raised the issue of improper personal motivation in each case and sought discovery of the medical records of other physicians' patients as well as the peer review records of those other physicians.

[335] 447 F.2d 839 (5th Cir. 1971)

[336] Id. at 842.

[337] Id.

[338] Id. at 844.

[339] Id.

standard has been applied, the one who fails to meet the standard has not been denied equal protection just because others have not also been subject to adverse privileging actions.[340]

The ruling that neither courts nor privilege hearing committees should consider the care or conduct of other physicians has been applied in other situations as well.[341] The *Woodbury* case dealt with the issue of whether a physician, through counsel, had a constitutional right to question the hearing members regarding their surgical judgment. In *Hayden v. Bracy*[342] plaintiff was required to undergo post-graduate training when a hearing committee determined that his judgment with respect to the proper indications for cesarian sections was questioned..[343] Instead, he moved his practice and challenged the actions of the hospital in court. The district court denied discovery of the medical records pertaining to cesarian sections performed by other physicians.[344] Plaintiff alleged these records were relevant as they showed he performed as well or better than his colleagues and the adverse action therefore had to have been motivated by malice and not a genuine concern for patient safety.[345] The court of appeals acknowledged the "tangential" relevance these records may have had, but they upheld the denial of discovery by the district court as not an abuse of discretion.[346]

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[340] Id, at 845-46.
[341] Peterson v. Tuscon General Hospital, Inc., 114 Ariz. 66, 559 P.2d 186 (1976) (the court held the fact that other physicians fail to properly complete and maintain records was of no significance).
[342] 744 F.2d 1338 (8th Cir, 1984).
[343] Id.
[344] Id, at 1342.
[345] Id.
[346] Id.

The case of *Smith v. Ricks* [347] addressed this particular discovery issue in the context of HCQIA. Plaintiff lost his cardiology privileges following a rather lengthy association with the hospital marked by repeated reviews of adverse outcomes and an ultimate finding of incompetence.[348] The district court granted defendant's motion for summary judgment, ruling that plaintiff did not overcome the presumption of immunity afforded by HCQIA.[349] Plaintiff challenged the investigation undertaken by the hospital in that he was not allowed to discover or introduce evidence of other physicians' conduct, essentially claiming to be no worse than they.[350] The court of appeals upheld the denial of discovery noting that nothing in the statute, legislative history or case law suggests the competency of other doctors is relevant in evaluating whether the hospital conducted a reasonable investigation into plaintiff's conduct.[351] In fact, the case law suggests that even if there is some evidence of hostility or personal animosity, this would be irrelevant to a determination of whether the hospital reasonably believed its action was in furtherance of patient care.[352] As the test of reasonableness is objective, bad faith is immaterial, and the only issue is the sufficiency of the basis for the hospital's actions.[353]

The argument that disparate treatment of one physician with respect to other similarly situated colleagues is some evidence of bad faith is not implausible. There is case law and

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[347] 31 F.3d 1478 (9th Cir. 1994).
[348] Id, at 1484.
[349] 798 F. Supp. 605 (N.D. Cal. 1992).
[350] 31 F. 3d, at 1486.
[351] Id.
[352] Bryan v. James, 33 F.3d 1318, 1335 (11th Cir. 1994).
[353] Id, (Citing Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992)).

ample anecdotal evidence that lends some support to this position.[354] Many states have passed statutes that grant qualified immunity to individuals who provide information to peer review bodies or participate in peer review actions as long as the information is provided and the actions are taken either "without malice" or are taken "in good faith."[355] If the hospital takes action against one physician, but ignores similarly poor care by others, that may be probative of bad faith by the hospital.[356] That suggests the medical staff does not truly view the care provided by the challenged physician as objectively unsafe, as they have overlooked similarly poor care in the past. Such behavior by the hospital may also be indicative of the application of an arbitrary or capricious standard or the arbitrary and capricious application of a facially valid standard, either one of which may violate due process. A direct comparison to other physicians allows the challenged physician to demonstrate that he has used the same diagnostic criteria and made the same treatment decisions as physicians who have avoided adverse actions.[357]

At first glance this seems to be a compelling argument. Theoretically, peer review involves measuring the skill and judgment of the physician who is the subject of review against some minimally acceptable norm. It is not unreasonable to argue that the acceptable work of one's peers, that is other physicians on the hospital staff, is the logical baseline for comparison. There can be other legitimate reasons for inquiring into the care of other

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[354] Rosen, supra, note 8, at 389.
[355] See, e.g. Cal. Civ. Code 43.7 (b) (1996); Cal. Civ. Code 43.97 (1996); Fla. Stat. 395.0193 (5) (1996); Ark. Stat. Ann. 20-9-502 (1995); C.R.S. 25-3-109 (1996).
[356] Rosen, Supra, note 6, at 389.
[357] Id, at 390.

physicians, as well. In the case of *Bolt v. Halifax Hospital Medical Center*[358] a physician contested the revocation of his surgical privileges. The decision to revoke rested on allegations of negligent care as well as several specific instances of unprofessional conduct.[359] Among the instances of unprofessional conduct was plaintiff's having called the family of the patient of another physician and advising them that their family member died due to the gross negligence of two other staff physicians and advising them to seek legal counsel.[360] The hospital also based its decision on one alleged case of negligence by plaintiff in which he placed sutures in a patient without the benefit of anesthesia.[361] In pursuing an anti-trust claim, plaintiff sought to prove an illegal conspiracy by introducing evidence through his expert witness that the conclusions reached by the peer review committee could not have been reached by any reasonable reviewer looking at the same set of facts. [362] The expert was also willing to testify that the care by the other physician, of which plaintiff complained, was so inadequate that it amounted to negligent homicide.[363]

Under the limited circumstances of the *Bolt* case it may have been appropriate to submit to the peer review committee the evidence of the other physicians' care. However, the relevance of the evidence and the purpose for introducing it was not simply to prove disparate treatment, and therefore bad faith. The purpose was not to demonstrate that there were other physician's whose care was no better, and in fact worse, than Dr. Bolt's. Rather,

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[358] 891 F. 2d 810 (11th Cir. 1990).
[359] Id, at 815.
[360] Id, at 821 n.16.
[361] Id.
[362] Id.
[363] Id.

the purpose was to demonstrate that Dr. Bolt's actions in discussing the case with surviving family members was appropriate and not an ethical violation.[364] If the care was, in fact, extremely poor and the hospital and responsible physicians were ethically obligated to share certain information with the family, it would justify what would otherwise appear to be unprofessional conduct on the part of Dr. Bolt. This is similar to the *McElhinney* case. What the physician is attempting to prove is that the hospital is punishing him for "blowing the whistle" on his colleagues. Rather than relying on the bylaw mandating an ability to work with others, the hospital is directly attacking the quality of his care. The quality of care of the colleague is relevant not to show that there are equally impaired physicians, indirectly demonstrating bad faith, rather it is directly relevant with regard to the motivation for placing Dr. Bolt's care and behavior under scrutiny. It appeared that the court may have shared Dr. Bolt's view that the peer review action against him was in retaliation for his calling attention to the other physicians' lapses.[365] They did not reverse the lower court decision so that Dr. Bolt could demonstrate that he was not the only poorly performing surgeon.

Such evidence of the motivation for pursuing peer review action is relevant for another reason as well. Although the general rule is that subjective intent is irrelevant, as the measure of the reasonableness of the belief that the privileging action is in furtherance of patient care is objective,[366] such motivation is clearly relevant to the credibility of the parties providing testimony or documents to the peer review committee. The credibility of those parties is relevant in terms of determining whether the care of the physician whom they are criticizing

[364] Id.
[365] Id.

was competent and, at trial, whether the hospital and the witnesses deserve the benefit of the qualified immunity offered By HCQIA or comparable state laws.

In spite of the "tangential relevance" of the care of other physicians, the admission and consideration of such evidence should be strictly limited, if allowed at all, to circumstances as in *Bolt.* The practice should not be allowed as a general defense to charges of incompetence. The legal and policy reasons for disallowing this defense greatly outweigh the value to the physician of presenting it. In spite of the holding in *Hayden v. Bracy*[367] this type of evidence is generally of highly questionable relevance. The issue under consideration in a peer review hearing is whether a specific physician is practicing with sufficient competence to maintain his privileges. The focus of that inquiry must be on the respondent's care and not on the care of others. The drafters of HCQIA and the courts in cases such as *Bryan v. James* recognize this. Even if there were evidence of hostility toward the physician under review or evidence of other poor performers against whom no adverse privileging actions have been taken, this simply does not address the issue whether the physician is practicing competently

Even if it could be demonstrated that some other physicians have had similar experiences in their practice, that is not probative of an equivalence in their skill level. Each case is unique and must be judged on its own facts. Further, even if such a comparison demonstrates some measure of equivalence, that certainly is not conclusive of bad faith. There are many reasons that would justify allowing one physician to maintain privileges while

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[366] See footnotes 329-30, and accompanying text, supra.
[367] 744 F.2d 1338.

taking adverse action against another. One physician may have demonstrated an amenability to corrective action and shown a great deal of improvement. Another may have been hostile and resistant to constructive criticism and demonstrated a recent decline in skills. Admittedly, these are somewhat subjective criteria, however, the hospital must still prove by competent evidence that the challenged physician practiced below standard and that they took action based on the reasonable belief that it would improve patient care.

One commentator noted that it would have been "relatively easy" in the *Hayden* case for the hospital to review all cesarian sections for a particular time frame and determine if his decisions to operate were markedly different from his colleagues.[368] It is not so obvious that this would be a simple task. Peer review of one physician can be a time consuming, labor intensive burden. It has already been noted that this aspect of peer review is one of the greatest disincentives to physicians to participate in the process. The demand on those who participate that the care of every member of the staff with similar privileges be reviewed may not seem "relatively easy" to those who must accomplish it.

One must also note that the physician usually requests to be allowed personal access to the peer review and medical records of other physicians. It is they who have the greatest stake in discovering and exposing other examples of incompetence, particularly by the staff members who may be sitting on the committee. Some states specifically preclude the use of peer review materials of other physicians by one who is contesting a recommended adverse

[368] Rosen, supra, note 6, FN 258.

action.[369] However, most states grant an exception to the peer review privilege if discovery is sought by a physician contesting adverse action, without explicitly limiting the exception to those records pertaining to the physician. Thus, otherwise privileged peer review materials pertaining to other physicians may be held to be available to one who is subject to a privilege hearing. The medical records of the patients of other physicians may also be accessible. This raises the specter of physicians and their counsel demanding access to some of the most sensitive information in the hospital's possession, based on the highly speculative and dubious assertion that they are relevant. This degree of disruption of the hospital's normal function is not justified nor constitutionally required.

Even if it were not unduly time consuming or disruptive, the proposed requirement would otherwise place a tremendous burden on the functions of privileging and peer review, while providing little in return. It is simply untenable that the price a hospital must pay in order to take privileging action against an allegedly incompetent physician be that they must review the care provided by the entire hospital or department staff. It is even more absurd to suggest that if an arguably similarly situated physician is uncovered, then whatever action taken, or lack of action, becomes a ceiling beyond which the hospital may not go in disciplining the physician under review.

It is clearly an excellent legal strategy to put the entire hospital on the defensive and put on trial the validity of the hospital's peer review program. Distracting the attention of the

[369] See, e.g. D.C Code 32-505 (1996); O.C.G.A. 31-7-133 (1996); 225 ILCS 450/30.3 (1996); Ind. Code Ann. 34-4-12.6-2 (1996).

committee to issues other than the competence of the physician may be the best hope in some cases for a favorable outcome. However, the ultimate purpose of the peer review process is the protection of patients, and the overriding consideration at the hearing should be the competence of the physician under review, not his colleagues, nor the overall effectiveness of the peer review program. Forcing the hospital to validate its program and to subject the skills of the committee members and the adverse witnesses to an equal degree of scrutiny is certain to have an extremely chilling effect on the willingness of any medical staff to point an accusing finger at their lesser colleagues. The evil that physician's defense counsel and some courts seek to be avoid in cases such as *McElhinney* and *Bolt* is the use of the peer review system as a punitive device to be applied to physicians who criticize the hospital administration or a more popular member of the staff. It is indeed ironic that those who would most loudly criticize this practice readily promote its use by physician's facing adverse action to punish or dissuade those who would criticize them. If it is inappropriate in one context, it is certainly inappropriate in the other.

Conclusion

Peer review is a vital component in the effort to improve the quality of health care by identifying those physicians who may require either additional training or the partial or complete revocation of their privileges. There is much about the process of peer review and its consequences that discourages physicians from actively participating. Legislative efforts have focused on protecting physicians who participate in the process from liability for

adverse actions taken against their colleagues, provided they act in good faith. These measures probably provide some degree of encouragement to physicians, but they are limited in their goals and their effect to avoiding litigation.

There are many aspects inherent in the process of peer review and privilege hearings themselves that serve as a deterrent to many physicians. The imposition of cumbersome procedural requirements that do not always serve to promote the interest of improved quality of care, but instead seem to serve as obstacles to ridding a medical staff of an incompetent physician discourages vigorous per review. In addition to initiating measures designed to avoid litigation, the conduct of peer investigations and privileging hearings ought to be structured so that they retain as much of their character as an autonomous quality improvement undertaking as is possible. This may involve limiting some of the procedural rights extended to physicians during these hearings. When they are dominated by trial type rules, they may be perceived less as a quality assurance function and more as a legal exercise. By limiting the emphasis on correct procedures and shifting it to assuring correct outcomes, we transfer much of the power over staffing decisions back to medical staffs and away from attorneys and the courts. This is almost certain to improve physicians' attitudes toward their own participation in the process of peer review.